MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Friday, September 18, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 9:25 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

C O N T E N T S

P R O C E E D I N G S

DR. WILENSKY: Let me start the session, please.

Let me remind people that we've made a change in our schedule for today. As is obvious, we did not start with the open session at 8:30. We have a two hour period scheduled for case-mix classification systems in post-acute care. We will have a break after that period for a short while.

We will start the graduate medical education discussion around 11:30. It will go for the scheduled length of time that we've allowed, an hour-and-a-quarter. We will have an abbreviated lunch break, it will probably be around 12:45 to 1:30. We will follow the schedule as it was posted for the risk adjustment discussion from 1:30 to 3:00.

So people who are interested in any of those discussions, I just wanted to alert them about the change in the schedule.

Julian, this is mostly your presentation day, but why don't you start the morning session and bring in the other presenters, as appropriate. Thank you.

MR. PETTENGILL: The materials for this

presentation are at Tab G and in the handouts in front of you.

Just a brief note on what we're going to do and the order in which we're going to do it. This presentation is in three parts. First, I'll give a brief conceptual overview of patient classification systems in the context of administered pricing systems. That is, what role the classification system plays in payment and how it's related to other components of the payment system, how classification systems are developed, and some issues to think about when you're considering any particular system.

Then Dana will talk about the resource utilization groups in the context of skilled nursing facility prospective payment system that is currently being implemented. And she will be followed by Stephanie who will talk about the status of the effort to develop a system for inpatient rehabilitation facilities.

These materials are really part of the foundation for potential recommendations in next year's March report. There are sort of two parts of the context here. One is that, as you know, the BAA requires HCFA to implement

prospective payments for most post-acute care providers in the next few years. As I said, the skilled nursing facility prospective payment system began -- is being implemented now for cost reporting periods beginning on or after July 1 of this year. The home health system is slated to be implemented beginning October 1 next year, and inpatient rehabilitation facilities payment system is scheduled for October 1, 2000.

Another part of the context here is that I just wanted to remind you that the payment system and methods that we focus on so much are dependent on and linked with a larger set of program systems. These include the supporting data systems, including the content of the forms that providers submit and the coding systems that underlie those claims, the audit monitoring and quality review systems, the provider certification policies and systems, and coverage policies. So one part of payment system design is to make sure that all of this works together, that the payment system is consistent with the other parts of the program and fully integrated with it.

I'd like to move on to the role of patient

classification systems in payment. In general, HCFA's goal is to ensure access for beneficiaries to reasonable quality of care without having to spend any more than necessary. That implies that the payment rates have to cover the cost an efficient provider would be expected to incur in furnishing appropriate care.

This raises at least three key issues. The first of these is what's the unit of payment going to be? The decision here is usually based on a variety of considerations but one of them is that, in general, other things being equal you would prefer to use a larger unit -- that is, a day is better than a service and a stay is better than a day -- because the larger unit creates broader incentives for efficiency.

Another consideration is what's the natural unit here, if there is one, for the particular provider? And then another consideration is at what level can we reliably distinguish the different products that the provider produces? Generally, this depends to a large degree on the information that is available in the particular setting.

And that leads to the second issue. If all

patients were the same, if there were no distinct products but just skilled nursing facility care was one uniform kind of care, for example, we would just pay a flat rate and be done with it and the payment system would be incredibly simple. But that's not the case, patients are different.

So the question is how do you distinguish among types of patients so that you can measure the expected differences in relative costliness that drive the distribution of payments to providers? That requires a classification system that identifies the different types of products and a set of relative weights that measure the relative resource requirements.

A third issue is how to set the level of payment rates. This is usually tied, in some fashion or other, to payments under the previous system. But that's not the focus of the discussion today, and we're more focused on the classification system.

There's really also a fourth issue that didn't fit on the slide, and that is the issue of how you update payments over time, including updating the classification system and the relative weights. Sometimes that becomes an

important consideration in how you define the classification system in the first place, or what underlying data you have to have to support it.

Let's go on. Having made all those decisions, what you generally end up with is a system that has a single structure. That is, the payment rate is equal to a base amount multiplied by a relative weight for the particular category of care that is furnished. The categories are defined by the classification system based on the data submitted by the providers for care provided to beneficiaries and the underlying coding systems. And the relative weight merely reflects or measures the relative costliness of a particular category relative to the overall average across all types of cases produced by that provider.

If you do this successfully, then the providers are not inappropriately rewarded or inappropriately penalized for treating patients with different conditions or different characteristics. They are rewarded for furnishing care efficiently within the bundle that is defined by the unit of payment and the classification system.

Let's go on to the issue of how classification

systems are developed and the criteria that are generally used. The classification system defines the distinct products that are going to be priced in the payment system. There's always a tension between what's conceptually desirable for category definitions and what's feasible.

Categories are usually defined based on knowledge of medicine and appropriate practice. But coverage policy and potentially undesirable incentives sometimes play a role, as well. For example, people are usually reluctant to set a separate for patients who die because if it turns out that you're going to pay a lot of money for someone who dies, the incentives are a little bit scary. I hope no one really believes that providers are going to go off killing people in order to get more money, but it looks bad.

Generally, the developers try to define categories that contain clinically similar patients who have comparable resource needs, both in terms of the mix and the quantity of resources that would be used to provide care. But this is often constrained partly by the limitations in available data and coding systems, partly by the potential for gaming, and also to some extent by basic ideas about what's the

maximum number of categories that you can have in the classification system and still have reasonable numbers of patients falling in each one, so that you can set a relative weight?

The last overhead lays out some issues that you generally might want to think about in considering a particular system. The first issue is whether the classification system supports the payment system objectives that you had in mind in the first place. That is, does it get us where we want to go, or does it at least move us in the right direction? Because sometimes you can't develop the system that ultimately you would want to have. You have to put in place something that's kind of an interim system that you'll want to refine later.

An important question here is whether the classification system and the weights account for at least a reasonable portion of the predictable variation in costs among patients. I say a reasonable portion because you don't want too much explanatory power. If you get too much explanatory power then you're explaining everything and there's no role for random variation and no role for

providers to economize on the cost of care.

At the same time, you don't want too little. You want the system to explain. If it explains too little, then it's not going to set fair rates that cover expected costs.

A second important issue is what's the character of the supporting data? Is it objective? That is, easy to audit and difficult to game. Does the provider submit the data or merely tell you what classification category the patient groups into? That's important because the data stream is crucial, in the longer term, to refining and updating the system over time.

Does the supporting data instrument facilitate the development of relative weights? To a large extent, that's a question of whether there's a usable measure of resource use associated with the data. Are you just getting clinical information or are you getting spending information, as well? If you're not, that potentially creates a bit of a problem down the road because the relative weights aren't necessarily tied into the changes in clinical practice.

A third issue is if similar care can be provided in other settings, how is it grouped and paid for there?

And is it consistent with the way you're doing it here?

That's not an exhaustive list by any stretch of the imagination. I'm sure other people will think of other issues that you ought to worry about, but those are some major ones that I thought of.

Now, if there are no questions, we'll go on to --

DR. ROWE: Can I make one observation? About your comment about not wanting to pay for patients who are dying because it's a scary incentive. Just to tie different parts of the agenda together, you know, we started yesterday with a very thoughtful discussion about care at the end of life. Obviously, it's probably just as bad, if not worse, to have an incentive to keep people alive because you're getting paid for the services you're giving them when they should have died. And if that's the incentive that we have in the system, a disincentive to identifying people and putting them in an end-of-life care situation, then that's also obviously ethically bankrupt.

So it's a minor part of this, but it's just one of the issues that I think this agenda fits together and, as we consider issues relevant to classification systems of post-

acute care, we should also at least include some thought about the relevance of the discussion yesterday about palliative care, end-of-life care.

DR. NEWHOUSE: Julian, I want to take you back to the comment you made about unit of payment. I think you said something like with other things equal, or some qualification, then a broader bundle of services or a broader unit of service was preferable to a narrow unit of service. Did I hear that right?

MR. PETTENGILL: Yes, within the context that you're determining a fee-for-service payment for a provider.

DR. NEWHOUSE: What I wanted to say was, it seems to me the qualification has to be either you can specify the bundle of services you're purchasing or you can specify some kind of outcome by which you're going to judge what you've purchased. Like if you buy an automobile, when you turn the key the car starts. You don't necessarily care what kind of metal you're inserting in the key, as long as the car starts. Or you've got kind of a detailed bundle of specific services that you've contracted for.

It seems to me neither of those is likely to hold

very well in health care, which is why we have all these debates about what the right way to price is. And it's not clear there is a right answer to how to price. I mean, I think I have in my head a right answer conceptually, but it's not clear that it could be implemented. In fact, it's pretty clear it couldn't be.

MR. PETTENGILL: That's exactly the problem. You have a series of trade-offs that you have to make in making these decisions.

DR. NEWHOUSE: Right. But then I wouldn't have said there's no presumption that a broader unit of payment is necessarily better because of the difficulty of specifying what I've actually got when I buy the unit of payment, or when I buy the broader unit. In the SNF case did I get enough physical therapy for the stroke patient if I just pay per discharge? Or indeed, in the fully capitated health plan case, what was the right amount of service? What was medically necessary. But let's keep it on the SNF case.

MR. PETTENGILL: At some point in the distant future the end goal may well be to be able to make payments

based on a specified set of outcomes, but we're --

DR. NEWHOUSE: Yes, but as I say we can all agree that we're not there, yet.

MR. PETTENGILL: Right. My sense is that we're a long way from there. In the meantime, it seems to me that the unit of payment decision really depends a great deal on what sort of classification system you can generate.

But I would also caution that you can't make the payment system do everything. The payment system can create a set of incentives that you think are desirable. But there also have to be other systems in play here that monitor the quality of care and help to ensure that --

DR. NEWHOUSE: We agree on that. I'm not even persuaded -- I guess I want to make two comments. One is there's no presumption that there is a single right answer here to the unit of payment. And second, indeed, I think that we may well want to consider some kind of mixed basis of payment rather than is this single basis better than that single basis of payment.

DR. WILENSKY: Any other issues?

DR. KEMPER: I just wanted to comment, first on

that issue of a broader bundle is always better than a smaller bundle, or other things equal. I guess the other things equal is pretty important. It seems to me the objective is to get things not too hot, not too cold, just right. We don't want to provide unnecessary care, but we also don't want to under-provide rehabilitation or therapy or whatever kind of care it is.

So if there's a lot of uncertainty about getting the incentives right to provide enough care, then you might not want to set up very strong incentives to limit care. So I think once you get beyond the conceptual level, that's the real rub here.

And the second comment is to come with sort of mindset, the way you described it I got a sense a lot of the case-mix issues being important to deal with distribution of patient mix across facilities and that that's the primary emphasis, as opposed to getting it not too hot, not too cold and setting up the incentives for the appropriate level of clinical care.

So I guess, in technical terms, more emphasis on the efficiency and appropriateness side rather than on the

distributional side. Not that the distributional side isn't important, but that that ought to be where we look at these data in the clinical side of things to get at that.

MR. PETTENGILL: I guess I would respond by saying that most people developing classification systems spend a lot of time and effort trying to get it right, in the sense that the categories are clinically meaningful categories that appropriately distinguish patients with very different needs. If you do the relative weights correctly, then what you're doing is not only helping to ensure a fair distribution of money among providers according to the mix of patients they have.

But in addition to that, you're avoiding creating incentives for people to select, that is to avoid taking on the patients with the most needs. And that's really important for access and quality of care.

MR. SHEA: The classification systems, is there any measure of improvement in health status that is built in or conceptually included here?

MR. PETTENGILL: No, generally not.

MR. SHEA: So what is the quality measure check

then, that you mentioned a few minutes ago, you need other systems other than payment systems?

MR. PETTENGILL: Right. Yes, you need a separate system. For inpatient hospital care you have PRO review. It can focus on individual cases or types of care, as it did in the beginning, or it can focus on patterns of practice as it attempts to do now. But you need a system that looks back at what happened.

DR. ROWE: I think, Gerry, to comment on that from a clinical point of view, it's very difficult. For instance, if you take patients with stroke -- and you could even be more specific and say right-sided parietal stroke. Very small differences in the size or the location of the stroke have a major impact on the functional capacity of the patient, how much they could recover. Their arm is going to be paralyzed or it's not, sort of, depending on a half a millimeter or a millimeter on the CAT scan. And the biology overwhelms the clinical output.

So if you've got that part of your brain out, you can have all of the rehab in the world and you're not going to be able to use your arm. So it really becomes very

difficult, unfortunately, to say okay this is a man with a parietal stroke and how much we pay will be influenced by whether he winds up being able to use his arm or something because it's just not -- the linkage of the diagnosis with the functional outcome is just not one-on-one. There's a lot of variety.

Another thing, in the beginning of medical school we try to impress upon medical students the difference between a disease and an illness. A heart attack, acute myocardial infarction. Some people have it and it's silent. They don't even know they have it. They went to work that day. Other people die of it immediately, other people are in an ICU. So if you take acute myocardial infarction and then say we're going to have cardiac rehab, well the amount of functional recovery or change over time is so dependent on the disease that it influences the illness. Patients with the same disease diagnosis will have very different illnesses.

So it's a little hard to do. I agree with what Julian says, you need a separate kind of thing.

There are some diseases in which you can do this,

like an anterior cruciate ligament repair, the patient should be able to walk at X period, a date, stuff like that.

DR. KEMPER: But, Jack, correct me if I'm wrong. On the rehabilitation, it's possible to and they do establish clinical goals for rehabilitation on a patient-specific basis.

DR. ROWE: On a patient-specific basis, yes, but not on a diagnosis-specific basis. It's on an illness-specific, that's my entire point. You could do it on a patient-specific basis prospectively and say for this patient, starting in this status, our goals are this. But if you put all the patients with that diagnosis in a bucket, parietal stroke, it would be unreasonable to say we're going to pay you extra if you can walk. Because some of them are always walking and others are never going to be able to walk.

DR. WILENSKY: Is there a way to try to make not only an initial classification but an initial classification functional impairment and then sort of an end, since you're talking about an --

DR. ROWE: That's done for every patient by the

physicians and therapists.

DR. WILENSKY: But in terms of a payment strategy, could you use as a start point both diagnosis and initial impairment and then --

DR. ROWE: I think you may be able to. The problem, of course, is you'd get into gaming because people would be setting goals that are too low because they know they're going to be able to get that.

DR. WILENSKY: Right, or impairment measures initially that were more severe than they really were.

DR. ROWE: Right. I think there is probably a way to do this. Certainly for every patient there is this kind of robust assessment of what their functional status is at the beginning and what their rehab goals should be. And it's influenced, you know, by what their social situation is, whether they have help, whether they live alone, whether in order to work they have to be able to right or read or walk or whatever.

DR. WILENSKY: Are we getting into the next section, by the way?

MR. PETTENGILL: I think to some extent. I mean,

some of these issues will be perfectly germane to RUGs.

DR. CURRERI: I just want to ask Jack a question. One of the problems I see with this whole business is that you're trying to set a fair rate for an efficient provider. But that efficient provider, the definitions get a little different. I mean, let's take your example, a stroke where you have partial paralysis rather than paralysis.

The end points are going to be very different, depending on whether the patient is an artist or the patient is retired and just needs activities of daily living to have a good quality of life or whether they need fine finger dexterity to continue their career. So when you start measuring efficient care here you almost have to define each patient or a patient outcome.

DR. ROWE: That's right. The treachery is relying too much on diagnosis alone. I mean, we could -- and you've heard this before -- but I could describe a patient to this group who is a 75-year-old man with a history of a heart attack, maybe a stroke and hypertension. And you couldn't tell me if that man was in a nursing home or sitting on the Supreme Court of the United States with those three

diagnoses.

So obviously we need to get to the next level of patient-specific, or at least some groupings of patients where the error on the one side and the other side is not so great. I mean that's what this is about, I guess.

MR. SHEA: I didn't mean to get us into too complex a discussion. I thought Joe had the right level of this, for this prospective payment was the right amount of therapy given? I mean, that's just sort of a much simpler cut at this.

It seems to me when you talk about this area of skilled nursing care, just given the history here of care being delivered or not being delivered for the amount of money that was paid, it just seems like doing a prospective payment system there poses -- I don't know, it seems like we want to be particularly thoughtful about what other measures can we try to get in as quickly as possible to make sure that the potential abuses don't...

DR. ROWE: That's right. Because you would be giving therapy which is of no value to a patient.

DR. NEWHOUSE: This may or may not be helpful, but

this issue of how to pay is not limited to health care. If you think about contracting with an architect to do a remodel, you can pay a lump sum, you can pay by the hour. The lump sum is analogous to the broad basis of payment.

You think about contracting with a lawyer to take a case. You can pay by the hour or you can pay a lump sum, the same kind of issue and same kind of potential incentive. If you're paying by the hour there's a potential to pad the bill. If you pay the lump sum there's an incentive to stint.

It's interesting to me, by the way, that in both of those other cases we seem to do it either one way or the other way. I mean, we observe both of those but we don't observe a mixture typically.

MR. MacBAIN: Just a quick interjection because I think Joe's example of the architect is an interesting one that I hadn't thought of before. In building projects I've been involved with there are two key people other than the payer. One is the architect who designed the building and then, through the construction process, became the payer's advocate. And the other is the contractor who actually was

responsible for assembling a team of people, ordering the supplies and getting the thing built.

Payments were made on a progress payment basis, subject to certification by the architect that the building was being constructed according to the specifications that I, as the payer had approved.

There is no architect in this model. We're dealing directly with the subcontractor, almost. I think that's one of the things you're grappling with. As payer we really don't have the expert advocate to tell us what's going on.

DR. WILENSKY: That was why we had put in the notion -- it's not an ongoing analogy, but it was why we had put in the request for an independent case manager reviewer after 60 visits to, in fact, put some distance between a physician who is asked to certify the need for visits and the actual home care provider.

DR. ROWE: Exactly. A clinically-based person who can sort of make a judgment.

DR. WILENSKY: Who has presumably neutral incentives.

MS. KELLEY: As you know, the BBA mandated the implementation of case-mix adjusted prospective payment for skilled nursing facilities. The transition to the PPS began in July.

This morning I'm going to review the basic elements of that PPS and at future meetings staff will present technical details about the SNF payment system in preparation for your March report. Also, we plan to explore issues that cut across all the post-acute care settings, such as the rationalizing of payment for similar services and issues related to the bundling of acute and post-acute care payments. So you can look forward to issues like that.

Before we turn to the new payment system, let me remind you of what was wrong with the old one. Medicare's payments to SNFs were based on reported costs. SNF costs are separated into three categories, routine, capital, and ancillary.

Medicare payments for routine costs, which include room, board and skilled nursing services were based on facility-specific costs subject to an input price adjusted national average per diem cost limits. New providers were

exempted from those cost limits for up to their first four years of operation. Since the number of SNFs grew more than 50 percent between 1990 and 1997, a fair number of facilities were operating without cost limits during that time.

In addition, many providers with reasonable costs that exceeded the routine limits were granted exceptions from the limits. Payments for capital and ancillary services, such as physical, occupational, speech therapy, laboratory tests, radiology procedures, were based on facility-specific costs without limits.

Under this payment system then, higher capital costs and ancillary use resulted in greater Medicare payments. SNFs also were able to use high ancillary service use to justify exceptions from the routine costs limits, thereby increasing their routine limits.

In this payment environment, Medicare expenditures for SNF services grew quite rapidly, increasing an average of 33 percent each year since 1986 and reaching an estimated $13.2 billion in 1997. SNF outlays now represent about 9 percent of Part A expenditures, which is up from 1 percent

in 1986.

Under the new PPS, a case mix and wage adjusted per diem payment is made to cover the routine, ancillary, and capital costs incurred in treating each SNF patient. The case-mix classification system that's going to be used is the resource utilization group system called RUGs, version three, which is why it's called RUG-III.

The RUG system first divides patients into seven categories, representing groups of patients with certain clinical conditions. Patients are then subdivided into 44 RUGs based on their functional status, as measured by limitations in activities of daily living and the number and types of services used.

The seven RUG patient categories are shown here. To give you an idea of the patients in each of these categories, rehab patients are those needing any combination of physical, occupational or speech therapy. Extensive services patients are those with a relatively large number of ADL limitations, who need tube feeding, suctioning, tracheostomy care or ventilator care. Special care patients are those with a relatively large number of ADL limitations

who require are for conditions like quadriplegia or multiple sclerosis.

Clinical complex patients have conditions like burn, coma or septicemia or they may need dialysis. Impaired cognition patients have difficulty in decision-making, orientation and/or short term memory. Behavior-only patients exhibit symptoms such as wandering, hallucinations, or physical or verbal abuse of others.

The system is hierarchical so a patient who has difficulty with short-term memory, by itself an impaired cognition classification, would be classified as clinically complex if she also needed dialysis. Patients not meeting the indications of the first six categories are classified in the last category, physical function reduced.

Each category is broken down into RUG groups, so as you can see here there are 14 RUGs under rehab and three extensive services RUGs, et cetera. Each RUG has a nursing index or a weight, indicating the average level of resources needed to provide nursing services to patients in that particular group. The rehabilitation RUGs also have therapy indexes.

The RUG system can be used for both Medicare and Medicaid payment. Generally speaking, patients falling into the top four categories here, or the top 26 RUGs, would meet the Medicare coverage criteria for special rehab and skilled nursing services. The remaining RUGs are more often used to describe Medicare patients.

Patients are assigned to a RUG group based on the results of required periodic assessments which are recorded in the minimum data set or MDS, which is a patient assessment instrument used to develop plans of care for nursing home patients admitted under Medicare or Medicaid. After each assessment the RUG group is recorded on the claim and sent to the fiscal intermediary for payment.

Assessments are reacquired on day five, 14, 30, 60 and 90. So the RUG to which a patient is assigned can and, in many cases, probably should change during the patient's SNF stay. Once a patient has been classified, the payment amount for that assessment period is determined. The payment will differ depending on the RUG to which the patient is assigned and the location of the SNF.

This overhead shows the Federal based per diem

rates for the SNF PPS. There are four components of payment. Each RUG has a nursing case-mix weight to which the nursing case-mix base payment is applied, $109.48 for SNFs in urban areas, for example.

The rehab RUGs also have a therapy case-mix weight to which the therapy case-mix base payment is applied. There are also non-case-mix components which recognize the fixed costs associated with the care of nursing home patients regardless of their clinical characteristics or functional limitations. All RUGs have a non-case-mix component rate added to the payment which covers the average costs of general services. That's the $55.88 for urban SNFs.

Non-rehab RUGs also have a therapy non-case-mix component rate to cover the average costs of the low level rehab services provided to patients that are not in the rehab category.

As an example, consider a patient with multiple sclerosis and a relatively high level of dependency in activities of daily living. The patient is classified in one of the special care category RUGs called the SSA group.

The nursing case-mix weight for this group is 1.01. Multiplying this weight by the nursing case-mix per diem rate for urban SNFs results in a nursing case-mix component of $110.57.

Since this is not a rehab RUG group, there is no therapy case-mix weight or added rate. The nursing case-mix component is then added to the applicable non-therapy case-mix components, which are the same for all patients. Here the other therapy non-case-mix component of $10.91 and the non-case-mix component of $55.88. The sum of these amounts is $177.36 and this is the per diem rate for any patient in this RUG in any urban SNF.

DR. ROWE: Per diem? Per day?

MS. KELLEY: Yes, per diem.

The total Federal rate would then be adjusted by the wage index to reflect the wage level in the SNF's market area. For the next three years, this rate will be blended with each facility's own specific rate starting with a 75 percent/25 percent -- 74 facility-specific/25 Federal -- going to 50/50 in the second year, and 25 facility-specific/75 Federal in the third year.

The Commission has voiced a number of concerns about the RUG classification system in the SNF PPS. One issue is the fact that RUGs relies on the need for services as a predictor of resource use. This creates incentives for providers, as you've just discussed, to furnish more services than are needed so as to classify patients in higher weighted groups.

On the other hand, some observers are concerned that using a classification system based solely on patient functional status could reward facilities if patients deteriorate into higher RUG categories. Using service provision to group patient then might counteract these other incentives to deny needed care.

Methods that might be used to limit or prevent the provision of unnecessary services or to ensure that necessary services are furnished are not discussed in the Secretary's interim final rule. There is no mention, for example, of whether or how audits might be carried out to determine if the service needs identified in the minimum data set are actually met.

Another problem is the lack of mechanism for

updating the initial case mix weights for skilled nursing and therapy services. Those weights should change over time as practice patterns, technology and payment incentives affect the amount of resources required to furnish the services. The weights may also shift as the patient mix within each RUG group changes, which can result from changes in admission practices or changes in coding behavior.

If the weights are not updated in response to changes in resource use, inappropriate financial incentives may be created and payment inequities may develop across providers. Aggregate Medicare spending for SNF services could be affected as well.

Yet another issue pertains not to the RUG classification system per se but to the unit of payment for which it was designed. The RUG system is used, as you know, with per diem payment. A per diem PPS creates incentives for providers to control costs by furnishing fewer services in a day. At the same time it encourages providers to lengthen the patient stay and increase patient revenues in that way.

If there are any questions, I'll take them.

DR. LONG: I presume this is a political and not an economic question, but why are the rural rates higher for the therapy non-case --

MS. KELLEY: Actually, I think that is an economic question. Those rates were based on cost data, so that is what the data suggested would be appropriate.

DR. LONG: Is that a surprise?

MR. PETTENGILL: The numbers that you were looking at were the standardized amounts. They're national standardized amounts and the rural rates are sometimes higher because that reflects the fact that rural areas tend to have lower wage index values. So when you standardize the national average, it goes up.

They may have had lower costs, but they also had lower wages. So when you standardize the cost values to get the national number, it actually moves up because you're dividing by a number that's less than one.

DR. LONG: It's a national standardized amount but for all rural areas?

MR. PETTENGILL: Yes. So it may appear to be higher than the standardized amount for urban areas simply

because the wage index values for rural areas are below one for the most part, while the wage index values used to standardize the costs are above one in urban areas and you're dividing through in both cases. So that's partly artificial.

MS. KELLEY: When the cost data is evaluated, looking at a rural SNF, it looks like it has relatively low costs. Those costs are adjusted for their lower wages to standardize them to a national average so that we can compare a rural SNF and an urban SNF or all rural SNFs by making it appear that their wages are all the same.

DR. NEWHOUSE: It may be economies of scale in an urban SNF that's showing up here. Another way, they've taken out the wage difference.

MS. KELLEY: Then once you have that national average for a rural area, then you can apply the rural area's wage index. In this case, I don't know, it was $56 for that non-case-mix component. 76 percent of that is considered to be labor related, and so the wage index will be applied back in to get that particular rural SNFs total.

DR. LONG: That's only for the nursing rates --

MS. KELLEY: It would be for all but that's one of the rates that is actually higher for rural areas than for urban.

DR. CURRERI: After the 90-day MDS is filed, then there are no more filings; is that correct?

MS. KELLEY: That's correct.

DR. CURRERI: What happens if a patient has a stroke after 90 days while in the skilled nursing facility? Can they resubmit?

MS. KELLEY: Medicare covers 100 days. So after that the patient would be a Medicaid patient or a private pay patient.

DR. KEMPER: Could you say a little bit more about this issue of using service use as a predictor? How does that actually get established? Is it the clinician's judgment in the nursing home about how much therapy is needed? Or is it retrospective based on the actual receipt of the therapy?

MS. KELLEY: It's both actually. The minimum data set that I put in the attachment in your meeting materials is the patient assessment tool that the RUGs classification

is based on. That is the took with which or by which the SNF determines how much rehab therapy they believe a patient will need, for example. How many hours of speech therapy and occupational therapy a patient will need.

However, the assessment is done, for example, the first assessment is filed on the fifth day. So there is some knowledge of what's been going on when the SNF files their assessment for payment on the fifth day.

DR. KEMPER: I guess the issue, it seems to me, is if I go to Bill and he says I need an appendectomy, we don't question that judgment in that case, or at least in most cases we don't question that judgment. But in the case of therapy, if the therapists are making a judgment about how much therapy is needed, it's an analogous kind of clinical judgment. There may be a lot more variation in what is judged to be clinically appropriate, but it still is a clinical judgment about need.

And so in a sense, I'm not sure this is stated quite right, as using resource use as a service provision as a predictor of resource use, as opposed to a clinical judgment. And then I think the issue is not how much

confidence but how much variation in judgment is there about how much use is needed.

I don't see how you could develop a therapy rate cell without having some judgments -- I mean, given Jack's comments about diagnosis as a wide range of need for therapy -- without having some clinical judgments.

DR. ROWE: I think the answer is you need a separate audit or check or review. If Bill does too many appendectomies which aren't needed, the pathologist reads those appendices out as normal and he gets to a certain percentage of those and the hospital administration sits down with him and says look, we've got a problem here.

So there's an independent mechanism for oversight in that case, in addition to professional reputation and other things, which are very powerful. So what you'd need in this case obviously, as we said before, was some kind of independent measure at some point of retrospective as well as prospective. Was this the right set of services?

MS. KELLEY: If a SNF were routinely categorizing patients in a RUG that indicated they would need X number of hours of therapy, and in checking later on it was found that

routinely the patients were getting half that amount, that would look like the SNF was classifying patients in a particular way in order to maximize their payment, as opposed to making honest mistakes in judgment, which you would think would go either way with about the same frequency.

DR. KEMPER: I guess my point is it's just not a system that's based retrospectively, making payments retrospectively. But it's not a service use. It's making payments based on clinical judgments.

MS. KELLEY: That's true, based on the judgment of what you think the service will be.

DR. KEMPER: But perhaps in an environment where there isn't a pathologist looking as routinely at the care and it may not be as clear. The pathologist's judgment might not be as clear.

MS. KELLEY: That's right.

DR. KEMPER: I guess I had one other question. That is, with the SNF use, do you have any sense of how many of the patients, what proportion of patients, are in nursing homes and remain in nursing homes after the end of the SNF

episode?

The reason I ask that question is that the incentive issues are very different if somebody either is or is going to remain a nursing home resident, then the issue of episode versus per day payment is largely an equity -- I guess exclusively an equity issue. At what point do you switch from Medicare to Medicaid or private pay status?

So the whole incentive discussion there is very different for those kinds of patients than for patients who are going to be discharged at the end of the SNF stay. If all were nursing home residents, then you wouldn't worry so much about the incentive effects of a per diem. It would be an issue of what's the maximum benefit under the SNF.

Do you have any sense of how --

MS. KELLEY: We don't have a good sense of that actually. We might be able to look into that, but I suspect that the discharge destination would not be especially reliable. But we can check into that.

DR. KEMPER: There are other data sets besides Medicare data. In all these areas, I think, the Medicare data may not be as strong as some other data sets.

But if you're thinking about an episode payment as creating an incentive for discharge, at least in an important portion of the patients, it's not going to create that incentive. It's just going to change the day in which they're switched to another payment source.

MS. KELLEY: Right. We do know that the average length of stay is relatively low compared to how long they can stay. It's about 21 days right now. So many, many patients are discharged relatively quickly.

DR. KEMPER: That's true, but that has to do, in part, with the copayment after the 21st day.

MS. KELLEY: Absolutely.

DR. KEMPER: Do you have a sense of typically what proportion of the total nursing home pay that $95 is? I think in some cases it exceeds the nursing home cost, right, in some circumstances.

MS. KELLEY: I don't know.

DR. KEMPER: It's a pretty high proportion.

MS. KELLEY: Yes, it is.

DR. NEWHOUSE: I just want to be clear on what I think you said and how the minimum data set gets used to set

the rate. I notice at the end of the minimum data set there's a case-mix group box where, I presume, the RUG group is put in and then that's consistent, for example, section T says ordered therapies. And section B is cognitive patterns. And section G is physical functioning. And section E is behavior patterns.

Those are the data elements that then get used to group the patient; is that right?

MS. KELLEY: Yes. But not all these data elements are always relevant.

DR. NEWHOUSE: But some subset of these are sufficient to group the patient?

MS. KELLEY: That's right

DR. NEWHOUSE: Then does the patient's status change potentially every time there's a new MDS assessment, for purposes of grouping?

MS. KELLEY: It could, sure. It could. For a rehab patient that was expected to recover, you would expect it to. You would expect their RUG to change over the course of their stay.

DR. NEWHOUSE: You said also the Secretary had

announced no audit provisions on this?

MS. KELLEY: That's true.

DR. NEWHOUSE: Does that mean there won't be any, or just the plans are still being drawn up?

MS. KELLEY: I hope that that means plans are still being drawn up, and I think that that is what is going on.

DR. NEWHOUSE: If it were drawn up, the group that would carry this out would be the PRO or some other entity?

DR. WILENSKY: No, people that do the survey and certification.

MS. KELLEY: Probably.

DR. WILENSKY: It would be the people that do the survey and certification.

MS. KELLEY: The MDS is sent not just to the intermediary but to the state agency, usually. So the follow up may be done at the state level, the survey and certification.

DR. NEWHOUSE: Like how frequently might this be done? Or is that all unclear?

DR. ROWE: The fact that there wasn't an audit

mentioned doesn't mentioned there won't be an audit. It will mean it would be done by this routine --

DR. WILENSKY: The group that does the deficiency assessment.

DR. CURRERI: How often do they that, Gail? Do you know?

DR. WILENSKY: Every couple years?

MS. KELLEY: I think so. I would assume that HCFA will put in place some sort of mechanism for reviewing these. But as yet, it has been unmentioned in the rule.

DR. WILENSKY: And I can't imagine they won't.

DR. ROWE: It would be essential, I would think, because of what we were talking about.

DR. KEMPER: And it's both sides. This shouldn't be divorced from the quality assurance side, either, that sufficient therapy is provided as well as not too much. And that's what I think gets this whole review process, both on are they over-providing care, needs to be meshed with some sort of quality assurance --

DR. NEWHOUSE: Now in the hospital case, the audit basically goes back to the chart. In a sense, is the face

sheet consistent with the data in the chart. Is that what you presume would happen in this case? I don't know anything about charts in nursing homes.

MS. MAXWELL: HCFA tells me that they're going to have the MDS data sent to them. In the past, before the SNF PPS, it was not needed to go there, it only went to the state. But with the SNF, they're going to send it out also to them and they're going to use MDS data and also they're going to do some audits on charts in the monitoring.

That's just a verbal discussion. They don't have any formal plans.

DR. NEWHOUSE: Should we say anything about this issue? Or do we plan to in the comment?

MS. KELLEY: We did mention it in our comment on the rule.

DR. WILENSKY: Presumably, at some point, just as HCFA noticed that there seemed to be a very high rate of complex physician visits and a very low rate of uncomplicated less than 15 minute rates, that if there seemed to be unusually high numbers of the most complex RUG classification, those are the kinds of things that you could

audit independently of the chart, as to whether or not those distributions made sense.

MS. KELLEY: Right, and that would also --

DR. NEWHOUSE: How would you know if they were right without going back to the chart?

DR. WILENSKY: Presumably, it is not just whether -- I mean, if you have any sense you have the chart consistent with whatever is in there. I think that in addition to that you would presumably want to do some other kind of spot audits.

MS. KELLEY: Right. And of course, that has relevance to the other issue I raised about readjusting the weights of the RUGs.

DR. KEMPER: Do you know how this HCFA review is related to the -- I forget what we learned about yesterday, the HAVEN, RAVEN, the quality assurance work that HCFA is doing. Are those meshed at all?

MS. KELLEY: I don't know anything about the HAVEN. Since it doesn't ring a bell, I'm going to say I don't think that they are one and the same, but I don't know.

DR. WILENSKY: Any other questions about this portion of the presentation?

Thank you, Dana. Stephanie?

DR. NEWHOUSE: Let me ask one more question. How do risk plans typically pay?

MS. NEWPORT: It can be everything from a capitated to per diem to whatever.

DR. NEWHOUSE: Do they use this kind of system?

MS. NEWPORT: No, it's a negotiated rate, usually.

DR. NEWHOUSE: But you could have a negotiated rate with a case-mix adjuster in it.

MS. NEWPORT: It could.

DR. NEWHOUSE: But the industry generally doesn't?

MS. NEWPORT: No.

DR. WILENSKY: Certainly not to date. Presumably, they'll follow what Medicare does.

DR. KEMPER: This is really more Medicaid payment methodology.

DR. NEWHOUSE: Yes.

DR. WILENSKY: Stephanie.

MS. MAXWELL: Good morning. I'm going to talk

about the issues concerning prospective payment for the rehabilitation hospitals and units.

As we know, the BBA requires implementation of a PPS for these providers by October of 2000. In the paper you have, in your materials, you see some background on rehabilitation facilities, patients, and payment policies. I also review the literature concerning some overlap of patients most commonly concerning the hip fracture and stroke patients between rehabilitation and skilled nursing facilities.

In the interest of time, I want to skip over that now and focus on what HCFA's proposal is and on the policy issues that are being debated.

In some respects there's more room for broad debate about the rehabilitation PPS and the SNF PPS, since in fact the BBA is much less specific regarding the PPS for the rehab facilities.

This overhead lists what's in the BBA on the subject. The law calls for a two year transition beginning in October 2000. During the transition, the payments will be a two-to-one blend of TEFRA and the PPS, and they must

be 2 percent less than what they would have been under TEFRA alone.

The law states that the PPS may use patient impairment, age, related prior hospitalization, comorbidities, and functional capability as case-mix adjustment factors. The BBA did not specify a particular system, as it did regarding the SNF PPS.

The law also states that adjustments will be made from time to time to account for case-mix change and scientific and technical advancements. It also specifies that update factors will be based on the market basket index, that wage adjustments will be applied, that outliers cannot exceed 5 percent of the prospective payments, and that special payments can be made for Alaska and Hawaii.

HCFA is in the early development stages of a rehab PPS that is methodologically similar to the RUG-based PPS recently implemented for SNFs. What that means specifically is that data will be collected from a stratified random sample of 50 hospitals and units -- that represents about 5 percent of rehab facilities -- for a total sample of about 2,000 patients.

Also, patient information will be collected using an instrument that's termed the MDS PAC. On one hand, that instrument is tailored to the short-term post-acute care patient, but on the other hand it's extensive. It's meant to be applicable to patients in skilled nursing facilities and long-term hospitals, as well as those in rehabilitation facilities.

I might add that, as we know, there's an entirely separate patient assessment effort that most rehabilitation facilities currently do. HCFA says that it doesn't want to ignore that system, but instead it will pull in that patient information. You might recognize the FIM-FRG and the UDS nicknames for those. HCFA will pull that information in and compare it with the data they have coming off of the MDS PAC.

Resource use will be assessed by measuring therapy, staff and other staff time, and by documenting services and procedures performed in the rehabilitation facility. All of this will be used to develop a classification system that predicts resource use on the per diem level and also develop a case-mix index that reflects

the relative resource use of each classification group.

The proposal is not the first choice of the rehabilitation community, nor is there full agreement between HCFA and other parts of HHS. Nevertheless, the project is going to be done by a collect of researchers under contract with HCFA extending from this month through April of 2000. There will also be a technical advisory panel composed of 12 people from the rehabilitation facility and research community.

Given that HCFA is developing a system in the same manner as the one developed for skilled nursing facilities, there's some value in going over in more detail the RUGs that are specific to rehabilitation in skilled nursing facilities.

As we've heard, the current version of the RUG system classifies nursing facility patients into one of seven hierarchies and eventually into one of 44 groups. In general, patients are classified based on the estimates of their service needs and their functional status. The rehabilitation hierarchy, which is the first and highest paid one is comprised of five subcategories.

Rehabilitation patients in SNFs are classified into one of the five based on a weekly assessment of the amount of therapy needed and on the type of therapy needed, including physical, speech and occupational. For example, patients needing a total of 12 or more hours of therapy a week by more than one type of therapist would be assigned to the highest of these categories, called the ultra high, in the system.

Remember though, that there's a loose standard of three hours of daily therapy in rehabilitation facilities. So if the classification system being developed sorts rehabilitation facility patients at all based on therapy time, those subcategories would start with something closer to the top two levels and move up a little from there.

Therapy time probably wouldn't be such a key factor in differentiating rehabilitation facility patients, though. Indeed you see here, in the SNF system, there's a tenfold and fairly well spaced difference between the time represented in the five subcategories. But you don't see that range of therapy time in rehabilitation facilities.

DR. CURRERI: Could I ask you a question here?

I'm just a little confused, let me give you an example. An extensively burned patient that has contractures and requires physical therapy. Would they be in a rehabilitation category because they fit one of these definitions? Or would they be in extensive services or special care? How do you decide?

MS. MAXWELL: They would be in one of those other categories if they could not endure therapy. For example, they might be in, for a couple of weeks, in the medically complex categories until they're stable enough to undergo therapy. They might move up into a rehab RUG as the clinicians estimate that they could benefit from the therapy.

DR. CURRERI: So they would go to the highest one for which they met the definition; is that correct?

MS. KELLEY: It's hierarchical system, so they start at the top and find the first one that meets the patient and go from there.

DR. KEMPER: Did I understand that 12 hours is the maximum here, but in the rehab hospitals it's a minimum of 21 hours?

MS. MAXWELL: It wouldn't be 21. There's not a strict payment qualification or anything regarding this three hour rule, but there is a generally accepted standard within the rehabilitation facility community that a patient should be admitted if they can endure three hours of therapy a day. And so that would be more in the 12 to 15 hour range over the course of the week.

So you, of course, wouldn't have a group or a system that came off of time with time classifications so low, of course, as you would see here. But more in the 12 to 15 represents the kind of patients that get into the rehabilitation facilities.

DR. CURRERI: Are we talking just about inpatient or outpatient, as well?

MS. MAXWELL: Inpatient only.

DR. CURRERI: So nobody would be in a low area as an inpatient, would they?

MS. MAXWELL: These are certainly not the time classifications that you would see in the rehab PPS. The rehab PPS, you can almost -- if they're going to have time measurements off of it, you would conceptualize it as almost

a band on top of this. There would be some overlap probably in the very high and ultrahigh as kind of the base, the lowest rehab categories from those facilities and go up a bit from there.

In the current RUG system for the nursing facilities, rehabilitation patients are further classified according to their functional level, as measured by the ADL index, and that puts them into one of these 14 final groups.

As Dana mentioned, after the SNF patient's initial assessment, facilities must reassess at days 14, 30, 60 and 90. The average length of stay for Medicare patients in rehabilitation facilities is 17 days. So on this classification schedule, if they keep that across facilities, the typical rehabilitation facility patient would be in one RUG for day one through 14 or for the majority of their stay, and possibly another RUG for a couple of extra days until they're discharged.

DR. ROWE: Is this for rehab units in hospitals, as well?

MS. MAXWELL: Yes.

DR. WILENSKY: Could you give us some sense about

the variation around that mean?

MS. MAXWELL: Yes, the average of 17 and for rehab units it's 16. For rehab hospitals it's 21.

DR. WILENSKY: No, I mean in nursing homes we know they tend to be bimodal, where you have a group that is discharged after a relatively short stay. And then you have that other group that's for a --

MS. MAXWELL: I think it's much closer on the rehab facilities. The mean/median mode are pretty close together.

DR. ROWE: And the per diem amounts are before adjustments?

MS. MAXWELL: This is before the wage adjustment, but this is taking the therapy portion and adding in the nursing portion. This is taking the example that Dana had, but it's just for each category. But it's not adjusted for urban or rural here.

DR. ROWE: And it's in addition to the nursing?

MS. MAXWELL: Yes, I added in the nursing component.

MS. KELLEY: So $384 would be the total per diem

payment for a patient in this highest RUG, the ultra high ADL score.

DR. NEWHOUSE: Before wage adjustment?

MS. MAXWELL: Yes.

DR. ROWE: Which would be nice if it happened. Do you know what the relative -- what that represents in terms of comparison to the previous payments? About the same overall?

MS. KELLEY: For rehab patients?

DR. ROWE: Yes.

MS. MAXWELL: I can't speak on the SNF side. On the rehab facilities side, as we know, they are basically paid on a case-based system. But if you take it down to a daily rate, their rate is closer off of their TEFRA payments, their rate is closer to about $600 a day.

Obviously, these are not the amounts that are proposed or have anything to do with the rehabilitation system, but it gives you a sense of the relatives that they have among their rehab patients in the SNF.

DR. ROWE: But when I asked you if this was for rehab hospitals and inpatient units, you said yes.

MS. MAXWELL: Oh, I'm sorry. I thought you asked whether or not the PPS is for units as well as for facilities.

DR. ROWE: I meant whether these numbers are for, and you said yes.

MS. MAXWELL: I'm sorry, I misjudged your question. I thought you meant whether or not the PPS applied to both. This is for the skilled nursing facility PPS and it just talks about the rehabilitation patients that are in SNFs rather than --

DR. ROWE: In nursing homes?

MS. MAXWELL: Yes. I'm sorry, thank you.

DR. ROWE: I'm looking at $1,000 a day and you're telling me it's $384.

DR. CURRERI: Let me ask you a question. Isn't the long-term proposal whether you're giving rehabilitation services in the skilled nursing facility or whether it's in a rehabilitation hospital the same services will be paid the same amount of money with wage adjustments?

If not, then this doesn't make much sense to me.

MS. KELLEY: I think that would be ideal only to

the extent that the patients are clinically similar, and we do know that patients in rehab facilities are not always the same as the rehab patients in SNF facilities. I think that's part of what Stephanie's trying to point out here, is that these are the payment amounts that were established for the rehab patients in SNF facilities, looking at this particular payment system, the RUG payment system.

Trying to expand it in some way or add to it so that it will work in rehab facilities as well would require obviously taking into account the different costs that patients in rehab facilities have which, in many cases, are higher because the services they receive are different.

DR. CURRERI: I thought the whole reason for getting away from TEFRA was so we didn't have to do the individual-based cost estimates for each institution and so forth, as well as different cost estimates when you go from one type of facility to the other. I had always assumed that one of our goals was to pay the same amount for the same services.

Now if you tell me systematically that patients in rehabilitation, which I probably believe you, are a

different group of people. There's no homogeneity with the patients receiving rehabilitation in skilled nursing homes because of various selection, whether it be physician or patient selection, that's fine. But then you need to tell me how you're going to go about readjusting these rates in a fair way for the rehabilitation.

MS. MAXWELL: I would say two things; one, let me continue.

[Laughter]

MS. MAXWELL: And two, there's a long term goal among HCFA to do what you said, which is pay appropriately for the services used. But that represents developing a common method. In no way does that imply that the rate would be the same. In rehabilitation facilities you might have just more rehabilitation and that is a higher rehabilitation cost. In skilled nursing facilities, many times you have less rehabilitation because you have patients that come in that have more comorbidities and a higher level of functional impairment. In those patients, their nursing costs would be higher than their rehab costs.

DR. ROWE: I think we get back to the issue that

what on paper looks like the same amount or type of treatment will be a different kind of treatment for different kinds of patients and it costs more and is available in different facilities. We have a young woman in our hospital who's a Chinese gymnast who broke her neck in the Goodwill Games. She got admitted to our hospital for rehab because she's acutely quadriplegic.

Now we could have sent her to a nursing home and she could have been listed as quadriplegic and need rehab services. But it probably wouldn't have been the same thing. You know, I mean there are differences, even though the diagnosis is the same.

DR. CURRERI: Well, I'm not arguing that. I'm just saying that the methodology, which I think you're going to get to, has to be outlined on how you're going to make those differentiations.

MR. MacBAIN: Just a real quick clarification because I think we're getting off track here. The model is not paying for services. The model is paying for days. We're saying that there is something inherently different in a day in a rehab hospital versus a day in the SNF because of

inherent clinical differences in the kinds of patients who are in the other. So we really shouldn't be talking about paying the same for the same service because service isn't even the issue. It's a whole different unit of payment.

MS. KELLEY: One thing I just wanted to clear up, Bill. Even if the payment rates were different for rehab facilities and SNFs, we are moving away from TEFRA in that there will be base Federal payment rates. Each facility will not have its own rate.

DR. CURRERI: I understand that.

MS. MAXWELL: In the paper I do review the research that compares the current RUG system with the main classification developed by the rehabilitation research community. I'm going to skip over that now but we can come back to it if you want. I just want to remind you that that's there.

Regarding the RUGs method, though, even within the SNF PPS, HCFA is engaged in some refinement work regarding these. Much of the immediate activity does relate more to the medically complex and special care patient groups for SNFs, but the larger point is that there is interest and

openness to refining the RUG system.

The notion of refinements is a good segue to this overhead because this lists all of the types of the patient assessment information that will be collected from rehabilitation facility patients in HCFA's case-mix classification study.

The MDS PAC is currently being field-tested in 40 SNFs that furnish rehab and medically intensive care and in 30 rehab facilities and in 30 long-term care hospitals. It's expected that the MDS PAC will be used for a classification in the SNF PPS eventually, as well as in the rehab PPS.

The rehab RUGs in the SNF PPS draw only from the functional status and the services and procedures sections. In other words, the estimates of the therapy time come off of the services and procedures and the ADLs come off of the functional status sections. But HCFA reiterates that all of this information will be assessed in the rehab facility patient study.

Based on other research, other likely candidates include the cognitive patterns sections and the diagnosis

patterns. And there's a much more enhanced functional status section in the MDS PAC than the MDS and the functional prognosis section is new to the MDS PAC and that is a part of the information that in the rehabilitation facility case-mix development system they will have information fodder for developing their system.

DR. KEMPER: I take it this is not adequate to do the FIM-FRG classification? These items are not adequate?

MS. MAXWELL: It's getting pretty close. Many of the rehab facility community, the trade groups, have been working for the last year.

Actually, let me back up a little bit. The MDS PAC did originate out of the sub-acute community within the SNF industry. The original MDS was used as a quality assessment and quality measuring tool for patients whose stays were longer than 14 days. So some of the SNF community that treated patients that did have stays shorter than that were pushing for an assessment system that did relate to the more medically complex and the rehabilitation patients and some that had the shorter stay.

So this did come out of more of the nursing

facility type of patient orientation and some of the other sections, like timing of patterns and mood and behavior patterns and continence reflect some of the early development that was coming out of that.

Now after the BBA was implemented, HCFA kind of switched gears and started working with the rehabilitation community and basically working with people that have the FIM-FRG system and the UDS and working on the scales of the different items and the functional elements, for example, to make the scales appropriate and to further allow crosswalks between the data system and the FIM-FRGs and this and the RUGs.

Just to say that there's been a lot of a work and a lot of collaboration with the rehabilitation community to bring in the elements on that data set that's used in the FIM-FRG into this.

But many of the rehabilitation community are concerned about the data collection burden of this patient assessment instrument. Their assessment tool is much shorter and more targeted to their facilities because, of course, this is meant to apply toward long-term hospital

patients eventually and the more sub-acute type of patients in the skilled nursing facility. So the data collection burden is a concern among the facilities that would have to collect this.

HCFA recognizes that concern but they do view this instrument as a really key foundation for their multiple case-mix systems and for their payment systems, but also as a foundation in their quality monitoring and for their longer term research across patient provider types. And also to further, or at least enable, a long-term policy goal, possibly a bundling, plus you keep payments with the initial hospitalization event.

So HCFA is very strongly in favor of having a system that is agreed upon by the industry and implementing it across the settings.

Finally, the choice of per diem or per episode unit of payment is a very widely discussed issue regarding the rehab PPS. As I said, HCFA is developing a classification system that predicts per diem resource use. Meanwhile, the BBA did not specify the unit of payment and the rehabilitation community generally believes that a per

case system would be more appropriate for their patients.

On the one hand, the greatest advantage of the per diem system would be its commonality with the SNF PPS. A common payment unit could reduce some incentives to financially steer the set of patients who could reasonably be treated in either the SNF or the rehabilitation hospital or unit. Common payment unit also could facilitate comparisons of resource use in patients in rehabilitation facilities and SNFs.

Those comparisons would be helpful for short-term system refinements but, as I said, they would also be helpful in providing the research base for longer term goals possibly, such as bundling. Some also argue that a per diem payment unit offers fewer incentives to fragment the services and unbundle them to other post-acute care providers which, in turn, might increase overall post-acute care expenditures.

On the other hand, the per episode system is inherently geared toward the functional improvement and discharge orientation of rehabilitation facility patients. Some argue that it does allow providers more room to better

allocate their resources over the length of stay.

Of course, these facilities already are operating under somewhat of a case-based system under TEFRA. Relatedly, a per case system offers fewer incentives to just rachet down the level of care and draw out the number of days.

In kind of a medium long-term, many prefer that SNFs and rehab facilities do operate on the same payment unit but some thing that a per episode system would be appropriate for both rehabilitation and SNF patients. The efforts in the SNF world to develop classification systems along that line were not very successful, in large part, due to classifying both the shorter term Medicare patients and the longer term Medicaid patients in one system.

In the paper I talk about some fairly successful but also quite preliminary research that developed per case system for only the Medicare covered SNFs. That system was also fairly predictive of resource use when they replicated it in rehabilitation facility patients.

To wrap up, I just want to mention where the Commission left off in terms of recommendations. In its

March report it did support the move to the per diem SNF PPS but it did recommend that further improvements might be explored, including possibly a per case SNF system. The report briefly discussed issues related to the rehab PPS but it did not make any recommendations.

Armed with a little more information and a little more time this year, the Commission might want to consider recommendations regarding the rehab PPS concerning its unit of payment, concerning the issue of a common metric across rehabilitation and SNF facilities.

Also, about possibly the issue of classifying patients as a function of the therapy time as the RUG system does, so far. And also, possibly a recommendation concerning the overall potential for other post-acute policies and research stemming from their broad-based data collection effort that they aim to have across the post-acute facilities.

DR. ROWE: Thank you, Stephanie. Your grasp of this is really obvious and it's very impressive.

I just want to make a comment. I think we have the PPS system for inpatient hospital treatments and it's

worked well, I think, in general and most people thing. So there would be an obvious tendency, based on that experience, to go to per episode payment.

And there is a difference there. The rehab guys might want per episode payment, and I can understand why, but the fact is that it's pretty predictable as the data show how long it's going to take for a patient to recover from heart surgery or some other problem that they're in the hospital for. But the motivational factors and the psycho-social factors are so important in rehab that how quickly somebody recovers and rehabilitations from a hip fracture or major surgery or stroke.

Some patients really get into it, they respond very quickly. They do very well. Others get depressed. They have comorbidities. They don't get along with the therapist. The family isn't as supportive, and they don't.

DR. CURRERI: Some wait until the litigation is over before they --

DR. ROWE: It's just so hard to predict with confidence how long it's going to take an individual patient to get to a certain functional recovery, where it's just

much harder than it is in the general inpatient medical/surgical area. I think that that's one of the things that adds a lot of the variance here.

I don't have a solution or even a preference one way or the other, but I do think that we shouldn't just blindly generalize our inpatient medical/surgical experience to this, because there are other factors.

DR. KEMPER: Excuse me just a second, Stephanie. The data you presented on how well you can predict the episode costs is you can predict pretty well. Did I read that correctly? With the FIM-FRGs, anyway.

MS. MAXWELL: Yes, the FIM-FRGs was pretty predictive. It was 33 percent of the per case resource use was explained.

DR. ROWE: 33 percent. What is it for hospitals?

DR. CURRERI: There was a paragraph that came just before that where the RUG system appeared to explain more than FIM-FRG. Maybe you could explain that out for me because I sort of read two paragraphs and couldn't put the two together. And I'm sure it's my fault in interpreting.

MS. MAXWELL: Probably not. What page are you on?

DR. CURRERI: It's the one where you talk about the explanation. It's on page 11.

MS. MAXWELL: When you're just talking about the predictive capabilities of the RUGs versus the --

DR. CURRERI: Yes, you said that the RUG-III system explained 54 percent of the variance in per diem while FIM-FRG was much less. But for case episode, those reverse; is that correct?

MS. MAXWELL: That 54 percent was for nursing facility patients. That's off of the original research development work for --

DR. CURRERI: I see, and the other is for rehab.

MS. MAXWELL: That's right. And FIM-FRGs is for, like you said, the rehab.

DR. KEMPER: But isn't it the case that it's much tougher to predict per episode costs because that includes the length of stay and the per diem.

DR. ROWE: That's my point. I may be wrong on that. That's my clinical impression, but I may be wrong.

MR. GUTERMAN: Let me correct a misimpression that I may have generated here. The FIM-FRGs explain 33 percent

of the per case variation?

MS. MAXWELL: Yes.

MR. GUTERMAN: The DRGs don't do nearly as well as that, do they?

MR. PETTENGILL: Yes, DRGs are more like 20 percent. Although the refined DRGs are comparable, at something like 33 or 34.

DR. ROWE: We should put my previous comments in the category of incorrect. Sound reasonable, but wrong.

MS. KELLEY: They're certainly correct. That's certainly what was found when they tried to establish or predict episode costs for SNF patients, or actually for nursing home patients, both Medicare and Medicaid.

DR. ROWE: Yes, my experience is some patients --

MS. KELLEY: Yes, your impression for those type of patients is correct. The difference in length of stay between a Medicaid patient and a Medicare rehab patient who happens to be in a SNF receiving their rehab is huge. So it was very difficult to do and that's why it was abandoned and that's why they went with per day.

DR. CURRERI: But I really agree with Jack, I mean

there are other psycho-social things that make it very difficult sometimes to predict length of stay. For instance, if there's no home to go to you can predict a long stay.

DR. ROWE: Absolutely. Chris Reeves went home soon because it was a pretty good situation.

DR. CURRERI: Which to me says you have to go per diem, at least in the short term.

DR. NEWHOUSE: That's what it says to me, too. But I wanted to make three comments. One was on the difference in the cost between the rehab facilities units on the one hand and the SNFs on the other. When I ask people around Boston, the clinicians, I get well, I usually send the patients that I think are going to improve to the rehab and I send the patients that I think are not to the SNF, which says to me there's some true but unmeasured differences in this patient mix, which I think is where Jack is coming from.

DR. ROWE: And I think there are two levels of that, Joe, because most of the rehab facilities -- at least the ones that I'm familiar with -- are full and have waiting

lists. So our rehab facility only takes patients who they think are going to improve. That is, they will only accept a patient, all other things like payers and insurance being equal, if they feel there's real rehab potential and the patient can benefit from these resources.

So not only is there a screen and a referral by the physician, but then there's an additional screen after the patient's assessed by nurses at the rehab facility. Whereas, the nursing home is much more likely to take every rehab patient that's referred to them.

DR. NEWHOUSE: I think there's a second potential reason for these cost differences maybe, although this gets to how they're measured, which is there's clearly incentives for the hospital to park overhead in different ways. So the question is how is that accounted for in these different costs, figures that are being tossed around? Are these just the direct costs of the unit?

MS. KELLEY: That would be an issue in both SNFs and hospitals.

DR. NEWHOUSE: Yes, SNFs and rehab. But it may be different. So when we're saying well, it costs X dollars

per patient in for rehab and Y dollars for SNF, I'm willing to believe that there are differences in these patients, but I want to know how the overhead differences are.

DR. CURRERI: And how about capital costs, too. I would guess that rehab the entire capital costs, but are they included in these numbers? I don't know.

DR. NEWHOUSE: That's my question. Are these just direct patient care costs before allocation or stepdowns or what?

MS. KELLEY: In the SNF PPS, the costs were from the cost reports so, yes, there certainly could be an allocation issue.

DR. NEWHOUSE: That's what I thought.

MS. KELLEY: Of course, in the SNF PPS, the way the rates, the cost data, was pulled together weighted the free-standing facility cost data much more heavily than the hospitals cost data.

DR. NEWHOUSE: I understand. But now trying to put this all together, this is still my first comment, coming back to Bill's point about the common system. If I were in the SNF, it seems to me I could be hearing a giant

sucking sound, to coin a phrase, if we have these different rates which may well be partly justified but may still result in a reallocation of patients.

And that actually leads, so it seems to me that where I come out is we probably want a more disaggregated system and we may have to still live with the different rates, but we may well see some reallocations as a result.

DR. ROWE: But you're looking at it as if you were starting de novo and you have these two systems, rehab programs and hospitals with rates that are X, and nursing homes with rates that are point-something-X. I think you have to understand that you're actually going into that system from a pre-existing system where the rates in rehab in hospital based programs are higher than they're going to be in the new system likely. In fact, hospitals are going to go out of the rehab business. You're going to have less access there.

Hospitals which have been making money on inpatient rehab programs are not going to be able to anymore and they're going to stop it and close those beds and they'll be.

DR. NEWHOUSE: It goes the other way.

DR. ROWE: Or it goes the other way, absolutely.

DR. NEWHOUSE: Whichever. The payment system is kind of getting in the way of -- or it's not being neutral, let me put it that way.

DR. ROWE: I'm not saying it's good or bad, but I'm just adding that to which direction to vector.

DR. NEWHOUSE: That's fair enough.

MS. KELLEY: We also don't know that it's neutral now.

DR. NEWHOUSE: The question is are they getting more neutral or less neutral and how would we know?

DR. ROWE: I think the factor now that's most important, at least in the market I'm familiar with, and I think in other markets, there's a relatively lack of high quality rehabilitation facilities and therefore there is this allocation of the patients, informally or formally, who are most likely to benefit from the certain resources to those resources.

Once you get more rehab facilities, more supply than there is demand, then that may not be the case, you

know.

DR. NEWHOUSE: Of course there's been a lot of entry into rehab.

DR. ROWE: In some places there's been entry but -- in the south there's been entry.

DR. NEWHOUSE: The number of units has gone up a lot.

MS. MAXWELL: There's about 800 units and 200 free-standing.

DR. ROWE: But it's geographic issue.

DR. NEWHOUSE: The other point I wanted to make to Stephanie, coming back to your modeling issue, that's all conditional now on the current patients in rehab. And there's no reason to think that the allocation is going to stay fixed if we've changed payment systems. It's kind of a corollary to the first one.

Also, in your last slide, do we want per episode or per diem, again we could have some kind of mixed system as an option. We don't have to have one or the other pure system.

And then the third point goes back to your first

slide, this is a more technical point. You said we're going to develop a system with a sample of 2,000 patients and it's got 15 categories? You meant a total of 2,000 patients.

MS. MAXWELL: The degrees of freedom are getting a little tight.

DR. NEWHOUSE: It seems to me we need to say something.

DR. WILENSKY: Why is that the case? It just seems like it's such a small sample size with 15 classifications, 2,000 can't possibly be enough.

DR. NEWHOUSE: That seems hopeless.

DR. CURRERI: It's probably a time problem in terms of getting that many patients through...

MS. MAXWELL: They'll probably have fewer categories than what's in the FIM-FRGs or the RUGs. Right now there's 44 in the full RUGs, which applies to all the other kind of patients. There's about 70 in the FIM-FRGs.

Absolutely, they're going to have problems if they are looking at that many groups.

DR. WILENSKY: If they have 15 they're going to have problems.

MS. MAXWELL: HCFA says that 50 facilities is a much larger share of the overall patient population than they were able to test within the SNF population, given that there's 16,000 SNFs. So their argument is that they're going after the representative facilities.

DR. NEWHOUSE: But there's variation across facilities and variation across patients and the variation across facilities does nothing to deal with the variation across patients. Or the within facility variance, let me put it that way.

DR. ROWE: The unit analysis is still patients, right?

MS. MAXWELL: Yes. I've talked with some of the people on the technical, but it's a brand new contract, people that probably will be on the technical advisory panel and they're raising exactly these issues. They're worried about the number of groups that can come out of this sample size.

DR. CURRERI: That really means just 130 patients per cell, right? Roughly. Some will be less.

DR. KEMPER: It seems to me we have a real issue

here of two competing objectives. One is the common payment system across settings, which is something we've stressed as being important. The other is the effectiveness of the payment system at getting the incentives right for a particular kind of service.

It seems to me we ought to look at the FIM-FRGs and perhaps this additional system that you talked about here in one of the articles, by Kramer I think, to delve into that a bit more before we go immediately to the per diem for the rehab patients. Because it seems to me we have one system that was developed for custodial care for Medicaid patients largely where the kinds of issues that Bill and Jack were raising about lots of factors affecting length of stay and family supports and so on.

And then we have another system coming from the rehab side which is really quite good at predicting episode costs, if I understand the evidence we've got here, and seems to have the incentives right for that. And then we've got this little intersection of patients at the SNFs that get some therapy.

I think one question is is it possible to identify

patients in the SNFs that meet the rehab criteria or are these selection mechanisms that Jack and Joe were talking about so great that there's no way to go to a patient classification system that would allow per episode payment for rehabilitation services? Rehabilitation is different from custodial care or even the skilled nursing care.

So I would like to see more analysis.

DR. ROWE: Peter, but it's important to understand, and you may and it may be included in your comments, when we're talking about the rehab that's in SNFs, these are separate rehab units in SNFs with separate management and separate patient referral patterns and patient assessment, et cetera. And the patient would get admitted to the rehab program in the SNF and referred to it. It's not like there's a general population of patients in the SNF and some are getting rehab and some aren't, one patient in the room gets rehab and the other one doesn't.

Generally, it's a separate unit in the SNF. Not always.

DR. KEMPER: Is that universally true?

DR. ROWE: No, but increasingly.

DR. KEMPER: That would make it more likely to be possible to have a per episode payment for rehabilitation services.

DR. ROWE: Stephanie will now tell me I'm wrong, but there are data, I think, to support that.

MS. MAXWELL: You're right, it does vary across facility, though. The formality of the rehab programs and the other sub-acute programs varies quite a bit.

MR. MacBAIN: Just a question on the per diems themselves for rehab and for SNFs and it's really two different questions. In negotiating per diem rates for commercial enrollments and in hospitals, one of the factors that always crops up is the extreme difference in costs as recorded by the hospital for the first day of the stay versus the last day of the stay. And when you average that out using a per diem and then proceed to reduce the length of stay, you end up with a disproportionate reduction in revenues relevant to the hospital's reduction in costs.

Does the same thing happen with either SNFs or with rehab? Is that first day or the first two days of a stay significantly different from the average per diem?

MS. MAXWELL: I can speak a little bit about the rehabilitation patients in SNFs. As we're talking about the fact that the rehabilitation facility patients are generally of a higher functional level or higher likelihood of improvement, they're strong enough to handle two or three hours of therapy a day. Some of the trends you see about rehabilitation patients in SNFs is that they are many times frailer than the rehab facility patients. They don't have very high rehab resource use at first. They have higher skilled nursing care use at first. That drops pretty much in a straight line down the length of their stay, but their rehab resource use increases as their strength increases and as they stabilize.

Actually, the presence of that kind of patient, that comes in with high functional impairment but low ability to withstand rehab at first, is a key difference in those two facilities. Measuring those two resource times separately is one of the keys to the success of the research that you were looking at that's in here by Andy Kramer.

DR. CURRERI: Do we have any measurement or estimate of the number of SNFs that subcontract out their

rehab versus having in-house rehab?

MS. KELLEY: No, we don't.

DR. CURRERI: I mean, I wondered where there costs are different?

MS. MAXWELL: I think that estimate can be gotten. But there is a very big contracting industry out there that goes into SNFs. But I don't know that.

DR. CURRERI: I don't know if that's something important we should know or not, because they're may be two sets of payments, depending on whether it's one in-house or it's subcontracted out, where there's a third-party making a profit, too.

DR. ROWE: That might also influence the allocation of overhead issue that Joe was talking about.

DR. WILENSKY: Any other comments?

MS. KELLEY: I don't know if this answers your question, but in a SNF under the former payment system there were three ways that ancillary services like rehab could be provided. The SNF could provide it themselves. The SNF could contract with an outside provider to provide it. The provider would bill the SNF and the SNF would bill Medicare.

Or the SNF could contract with an outside provider who themselves would bill Medicare under Part B and the SNF would have nothing to do with the payment of that portion of the rehab.

We do know that third category, where the outside provider billed Medicare directly for the services they provided, was actually -- ProPAC looked into that and that was actually very small, a very small portion of total spending.

Those separate Part B payments were estimated in developing the payment rates for the new SNF payment system. So the spending that was sort of lost from Part A, they tried to capture it back in when they were estimating the payment rates.

DR. CURRERI: The reason I ask that question is it's conceivable to me the costs might be very different or significantly different, depending on whether it's in-house or whether there are transportation costs and van costs and so forth of taking them to outside rehabilitation facilities and so forth. So you really might not have a homogeneous cost basis if you're looking at different arrangements.

I really don't have any idea whether this is significant or not but I think maybe it's important that we know.

MR. GUTERMAN: Bill, there's another source of difference in that arena. That is for the therapists who were contracted by SNFs and who had their costs passed through the SNF to Part A. The charges of the therapist were considered the SNFs costs. So all of the therapist's overhead and profit and everything was considered a SNF cost in that process, so it would have presumably some effect.

MS. MAXWELL: Also two points along that line, Bill. One is, before the SNF PPS they didn't really care how big those costs were for those in-house people or if they contracted it out, because they were paid their costs. There weren't any cost limits on those.

But definitely within the SNF industry there's a lot of assessment of their own capabilities and their own rehab patient load, to figure out whether or not facilities that used to contract out should continue contracting or whether or not they would provide it more efficiently in-house.

Also, within the contract therapy world, there's a lot of activity from the larger companies in developing products and cheaper products. Everyone knows that the contract therapy business is going to have to come in with a little lower prices for the SNFs in order to keep the contract business.

MR. PETTENGILL: That's because under consolidated billing the SNF is responsible for the whole claim. It can't be billed separately.

DR. WILENSKY: Any other comments?

MR. MacBAIN: Can I just go back to follow up on my earlier question? I'm just speculating, but is it possible then, as you're talking about at least in a SNF unit and I presume the same thing could happen in a rehab hospital, that the intensity of use and the actual cost per day goes up over time as the patient gains strength, could you find in those last three or four days of the stay you've actually got the highest cost days but because restrictions on ADLs goes down you could drop into a lower RUG and be paid less for the days of highest cost?

MS. KELLEY: It's possible. But at the same time,

one of the factors in determining the RUG category is the number of therapy hours used. So it's going in both directions.

MR. MacBAIN: That reinforces that need to look at resource consumption as well as patient -- these particular patients for instance.

MS. KELLEY: Exactly. Right.

DR. ROWE: Last night we were talking about a field trip to see some Broadway shows and some good restaurants, maybe seem some palliative care or home care. And those arrangements are underway.

But anyway, if the staff decides to do something like that, it might not be a bad thing to show people in in-patient hospital based rehab program and a first class nursing home rehab program, right across the street kind of thing. Something like that. If that's useful, that could all be arranged.

DR. WILENSKY: I think it would be of interest. The difficulty in this area, I think, is that the variability is so significant that unlike some areas this probably will show us what it might be in one kind of

arrangement.

DR. ROWE: Sure. It's not representative.

DR. WILENSKY: But what we would really need to do is to get some sense about, weighted by frequency, the types of arrangements that occur. It's not always the case that that would be so important, but in this area where the variability sounds like it's so great, it would tell us something. It would tell us far less than it might appear.

DR. ROWE: I think that's right. Coronary care units all look the same pretty much. These things look very different.

DR. WILENSKY: And the implications for the desirable reimbursement system and one that makes trade-offs between the desirable and undesirable incentives associated with each of the various reimbursement systems gets much trickier.

Are there any other questions from the Commissioners? Why don't we allow public comment on the post-acute, if people would have any comments to make?

MR. KALMAN: My name is Ed Kalman and I'm general counsel to the National Association of Long-Term Hospitals.

I just have a few comments to make. Understand that the long-term hospitals have also been included within the HCFA MDS-PAC study, so we have been involved in this.

With regard to the issue of paying on a per diem, one matter that has occurred to us that was not discussed here is that since the incentive of a per diem is to produce more days then we, long-term hospitals that take care of the extreme outlier portion of the Medicare program, have to be concerned about the inappropriate incentive to use patient days. That is for patients to prematurely exhaust their Medicare benefit because providers have incentives to produce more days as opposed to discharges.

We also know that in the market there are chain organizations that own both, especially hospitals and SNFs. An incentive would exist to exhaust all the Part A hospital days and all the Part A SNF days, especially if we're talking about the same payment ultimately, a high weighted rehab payment or high weighted long-term hospital RUGs payment regardless of the setting in which the service is performed.

Now you will hear, at some point, that our part of

the industry is developing our own PPS alternative which is based on DRGs weighted for this type of patient. But what we've done to try and address this, and some other policy concerns, is to greatly expand the transfer rules so that there is no incentive to discharge too early but there also is an incentive to discharge.

I don't think it's a whole answer but at least it marches down the road that I think Dr. Newhouse was going down.

Another aspect of a per diem payment, especially this type of per diem payment using the minimum data set is it encourages the lowest resource use to qualify for each RUG's category. We don't think that's wonderful for medically complex hospital level patients, especially where the incentive is more patient days.

The sample size of 2,000 patients is also being applied to long-term hospitals. Since, in order to get into a long-term hospital, you have to be acute, the same as to get into any other hospital -- the only difference is length of stay and some specialized programs -- we think that that system will not work well for acute patients. And I don't

know how you take a minimum data set that was constructed for custodial care patients and, using a sample of 2,000 patients, make that valid for hospital level patients.

The study we're going has identified, I believe, approximately 180 or so DRGs that are used significantly by long-term hospital patients. We've got about 140,000 cases in our database because we're using Medprior data when the data is available.

So these are significant issues that I hope you consider as you make your report to Congress.

DR. WILENSKY: If you'll make the data available to Murray and the staff when it's available.

MR. KALMAN: This project has been going on since before the BBA and from time to time we meet with policymakers. We have met with ProPAC and we have met recently with Stephanie and other members of your staff. And we'll be doing it again. The study is about complete.

Thank you.

DR. WILENSKY: Thank you. Are there any other comments?

We're going to go into a brief break, about 10

minutes or so, and then we will reconvene for the GME discussion. Thank you.

[Recess.]

DR. WILENSKY: Craig?

MR. LISK: Today I'm going to talk about graduate medical education and our proposed outline for the report, and discuss some of what's going into the report, the type of analyses that we're talking about hereto. What I want to start off with is basically just discussing again and reminding you where our mandate is for the report that's due next August.

The first aspect of the mandate and the general question that MedPAC was asked to address was to examine and develop recommendations on whether and to what extent Medicare payment policies and other Federal policies regarding graduate medical education and teaching hospitals should be changed. Within that mandate, Congress asked us to make recommendations in five specific areas.

Those include recommendations on possible methodologies for making payments for GME and the selection of entities to receive such payments. This also includes

issues concerning children's hospitals and also whether and to what extent payments are and should be made for training in other health professions such as nursing and allied health training programs.

The second recommendation area was concerning Federal policies regarding international medical graduates or also graduates of foreign medical schools. The third area concerned defense of medical schools on service-generated income.

The fourth area which I think is probably similar in some aspects to the medical school issue concerns developing recommendations concerning whether and to what extent the supply of physicians in the aggregate in the different specialities will change in the next 10 years and to what extent such changes will have a significant financial effect on teaching hospitals.

Finally we are asked to look at methods for promoting an appropriate number of mix and geographic distribution of health professionals.

So the outline we tried to address all these questions that we've been asked to address. Here we start

off with the background, but before that we will have some combination of introduction, executive summary, and preface to help provide a context of why we're doing this report.

What I want to go on to is to describe what the bulk of the report will be. The first part will be a background section. From the panel that we had back at MedPAC back at the end of July, we had an expert panel with several, about 15 or so, experts related to graduate medical education and teaching hospitals, both in the research community and also providers and payers.

And we had a lot of good information in terms of the discussion that we had that helped us in developing this outline for this report. One of the things they emphasized that was very important they thought was providing some information on the current payment and financing system, but describing the historical role of Medicare and the Federal government and private payers in the support of medical education, but describe why we have the current payment system we have today, how it historically developed from before Medicare to Medicare to the aspects of prospective payment, when that came in for hospitals. So why do we have

the current payment system, the structure we currently are presented with? So that would be one part of the background section under the current payment and financing system section.

Then we plan to, also, similar to what we did in the March report in volume 2, describe the current GME payment and financing system and how it works. That would be some detailed explanations of specifically how Medicare currently pays. We'd also be describing some of the sources of financing for GME and teaching hospitals in that section, but describing Medicare's payments to the extent we have information on Medicaid policies and the variation of policies across states, describing a little bit about that, including some information on DOD and Veterans Affairs financing for these programs.

Also important here, in describing the current financing system, is the programs that HRSA -- Health Resources and Service Administration -- sponsors, that affects some of the physician distribution, geographic distribution and other related matters.

Also talking about the current payment financing

system, you also want to describe how payments are distributed across providers and give you a sense of that. And then finally, when we talk about under the current payment financing system, one of the aspects that we need to look at is also nursing and allied health. You were asked to look at that, so you also describe the current financing system to that, to what extent Medicare is a major contributor to the financing of those programs and that they're hospital-based versus other locations.

The next section, under the background, will be discussing teaching hospitals and their joint mission. Here we plan to describe the activities of teaching hospitals from the different patient care activities that they undertake to the different types of teaching that may actually be undertaken there, from undergraduate, graduate medical education, to nursing training and allied health, the aspects of research and technology development that they're involved with, to their care for specialty types of care including complex cases, looking at the extent that teaching hospitals are the primary provider or looking at how much they're involved in providing care to the most

complex cases.

Also issues related to this, in terms of background, is looking at standby capacity and new technologies that teaching hospitals often are the first to develop. Care to the poor and unfunded patient care is also an activity related that's often mentioned that teaching hospitals are involved in.

So within all this context of these activities, we want to describe how these activities are distributed across facilities and how unique they are to teaching hospitals. We also want to discuss where else they take place, because other providers also undertake these activities, not just teaching hospitals. And there's a varying degree that certain teaching hospitals undertaken these activities. It's not an all or nothing matter.

So giving a context to this, we also want to describe how these other functions are funded in other settings and typically how they're funded in teaching hospitals, to the extent we can.

One of the aspects that it's commonly discussed, with Medicare and direct medical education adjustment, and

the purpose of that in some sense is the impact of these activities on patient care costs. So that would be another aspect of the discussion here as well.

Again because medical schools, in many cases, are closely tied to many teaching hospitals, we want to discuss some that interrelationship and what goes on there, in terms of the implications for financing and costs and those matters.

The last part of the background section will be looking at resident and physician supply and specialty distribution information. Here I think the first part we will be discussing the licensure and training requirements for physicians, because a lot of those requirements are not Federally established. The medical licensure depends some on the states and some of the determinants of decisions for certification of residency programs is based on residency review committees and other related matters. There's also who decides what programs become approved programs. So describing some of that aspect for the context of the training programs.

But then we'll want to describe some basic

information on current physician, resident supply and specialty distribution, information similar to what you have in your briefing books that was included in this year's July report.

And also within this area, too, we're going to describe some of the information that we have on supply and distrubution issues related to other types of health care professionals, nurses and different allied health professions.

So that, I think, provides the basic background foundation that our readers may want to have to providing a context for discussion of the issues.

The issues we have broken down here, in terms of the discussion -- and I envision this as probably the discussion. The issues will be sort of an even-handed discussion of these issues. The first one will be a discussion of Medicare's role in this whole financing system and discussing Medicare's role as a payer and also the equity issues concerning Medicare as the only payer that explicitly pays for these expenses nationwide.

Also, within this context, probably discussing the

public good aspects that's often brought around by the graduate medical education and the issues surrounding that.

The second issue is looking at the evolution of the health care market and delivery system and the insurance market and what impact that has on the financing of these expenses from what we currently have. And so there are a lot of issues as we get a more competitive market, in terms of how it's involved, concern that the current way of financing systems may not be able to finance these costs in the future.

The next part is talking about Medicare's current payments and how it pays, and a lot of the issues surrounding Medicare's payment system. That goes from incentives of the payment system, in terms of what incentives it puts on the system, both in a broader context from just the influences of how physicians are paid and might influence specialty choice decisions of residents and such.

But then there are finer distinctions in terms of the issues and incentives in terms of Medicare's role in determining the number of residents needed for future

physician workforce needs, desired specialty mix, and where physicians eventually practice.

The second part of Medicare issues that we'll be exploring is also accountability. This is an issue that was brought up by the panel and has been brought up frequently, is the lack of accountability within the current payment system, both from an output standpoint in terms of what we produce for physicians, but also for what providers who get these monies do. If we think of the indirect medical education adjustment, in terms of also funding other types of missions, there's no guarantee or no requirement that those other activities -- that the teaching hospitals undertaken those activities or continue to pursue those other activities such as research care to the poor and such, and those matters.

Finally, there's some issues concerning the specific Medicare payments, the indirect medical education adjustment and some of the issues surrounding there, concerning the level of the adjustment, how the adjustment is potentially a blunt approach for funding other types of expenses that teaching hospitals undertake. There will be

discussion of the issues surrounding Medicare's direct medical education payments, concerning the variation, talk about whether this variation is important to recognize or not concerning how Medicare share is determined and some of those issues related to the direct payment.

Also here though, which applies both to the indirect and direct payment, is discussion of how this is also a hospital focus payment system. The BBA made some small changes that have moved to funding training in other places, rural health centers and Federally qualified health centers as well as Medicare+Choice programs. But again the system basically does remain hospital focused. So it's a discussion of those issues with how care delivery is changing, and so discussion of whether hospital focus payment continues to be the appropriate focus of the payment system.

And finally, we also have to consider teaching physicians in the context here of Medicare payments and the policies that Medicare has regarding teaching hospitals. There's a general objective not to avoid double payment here, but there's a number of issues that go there.

When we consider all the parties that are involved here, what residents do, there is the whole issue of the complexities of funding, what is a joint product which is patient care services, teaching, training of residents and other activities that teaching hospitals pursue.

The next issue area that we'd be discussing is issues concerning physician workforce issues. Here we have the different issues concerning physician supply and discussing the implications of perceived oversupply of physicians, discuss issues related to the supply and demand, particularly future supply and demand needs that the country may expect. And also, discuss the implications these changes might have on hospitals here, in terms of a discussion of those issues.

There's also the issues of the international medical school graduates. Here we would be discussing the implications of using Federal funds to support the training of physicians who, for instance, may return to their native country. There are different opinions on that, in terms of it being something as a national good to do that type of thing, in terms of making sure other countries have well

trained physicians. But then there's also issues that a lot of these people, regarding immigration policies, remain in this country and find ways to get around those requirements.

The other issues, in terms of physician workforce, deals with specialty mix issues, in terms of primary care versus other types of trainees.

And then dealing with issues for health profession shortage area concerns, and discuss issues surrounding policies targeted towards encouraging physicians to practice in underserved areas.

Also related to physician workforce is a discussion of the issues surrounding nursing and allied health workforce issues and the funding of those activities. There's been a tremendous increase, actually, in a lot of nurse practitioners and different allied health professions and physicians assistants and such. That also has implications for future workforce needs, potentially on the physician side.

Finally in the discussion of the issues, is again we're asked to address the issues of the medical schools and the dependence on service generated to income. So we'd have

a discussion of medical schools and also probably the underlying research establishment, the medical schools involvement there and the issues of how those activities are funded and Medicare or the Federal government's potential role in those activities.

So that describes basically the policy issues section and we envision that as basically trying to be an even-handed discussion of those issues.

So with that we can come to what is the final section of the report, which would be policy reform. Here we have basically two sections, or it might be considered even three sections depending on how you want to handle what's under item B. But it's objectives.

So I have laid out in the outlines what might be perceived some objectives, and I think the Commission will have much more discussion to find what those specific objectives of Medicare and Federal policies might be. But I just gave you a flavor of what type of thing I was at least thinking of, and we were thinking of as staff, as what objectives or types of things they may be, and discussing about objectives of Federal policies regarding here.

Issues like creating better accountability in terms of what we have in the payment system, which we don't currently have, ensuring a well-trained workforce, ensuring preeminence of U.S. medical schools, but also allowing Medicare to be a prudent purchaser for what it's doing in terms of its responsibility to its trust fund and those matters, as well.

The final section of the report will be options and recommendations. Herewith the Commission, we probably will bring forward at different times options for you to consider or we want to her from you different options that you may have. But we have this section to develop final recommendations. We basically have this down to three basic sections, in terms of financing, payment methods, and also workforce issues and discussion of the options and recommendations the Commission might pursue.

So with that, I guess I can help answer any questions you might have. We did send out recently, as part of the continued consultation process, we sent out another letter to a bunch of people asking for comments of the basic question that MedPAC was asked to address, in terms of what

concerns people might have with Medicare's current payment policies for graduate medical education and teaching hospitals and identifying any recommendations or changes in policy they think might want to be considered. We'll share those with you when we get them.

I'd be happy to answer any questions and anything you want to discuss concerning the panel, as well.

DR. WILENSKY: Bill, Jack, Gerry, Joe.

MR. MacBAIN: Just a quick question to get a sense of where we're starting with this. In focusing on those objectives and recommendations, should we be looking at Medicare policy issues or Federal health policy issues? Should we have a broad scope or a narrow scope on this?

DR. WILENSKY: We clearly have to talk about Medicare. I think it might be helpful to make that distinction, but obviously it will depend on what other commissioners feel, in terms of Medicare. I think in one of the last comments that Craig just made about Medicare as a prudent purchaser that leads into the issue of Medicare and Federal government as distinct from Medicare.

So I would think that to the extent that we can

have that, it would be useful to do that.

MR. LISK: I envisioned that one, too.

MR. MacBAIN: My own sense on that is that there are serious broad policy concerns dealing with how the Federal government wants to support the education of graduate level physicians and provide support for safety net hospitals, particularly inner-city hospitals, that transcend the Medicare program. In fact, the Medicare program may be a very well poor way of trying to accomplish those objectives.

We may, just by the nature of the law that created us, be limited to dealing only with the Medicare program. But if you don't have a sense that we are, I'm perfectly willing to step out onto the thinner ice around the margins.

MR. GUTERMAN: The legislation requires us to consider Medicare and other Federal policies related to medical education and teaching hospitals. I think the focus is clearly Medicare but we certainly have the mandate, if not the requirement, to consider the other policies that touch on that.

DR. ROWE: I thought this was a thoughtful,

comprehensive, and very ambitious task and outline, and I had a number of comments and questions. I guess in no particular order, but I think that in your section on teaching hospitals and their joint mission and you describe the structure and function of teaching hospitals. In that section, I think it might be worth including a section on the financial impact of GME on teaching hospitals, since this is about GME and about teaching hospitals.

There is this funny thing about the impact of practice plans on the strength of medical schools which I wasn't clear at all on how that related to GME, but I guess that's in the BBA that we're supposed to talk about that? That would seem to be much less germane than the impact of GME on teaching hospitals for this current report.

MR. GUTERMAN: You mean the activity or the funding? When you say the impact of GME on teaching hospitals, do you mean GME funding or GME activities?

DR. WILENSKY: Or GME costs?

DR. ROWE: Yes, finances, impact on margins. I mean, if we're talking about teaching hospitals on the GME report, we should probably talk about -- because it's very

variable. There are all different kinds of teaching hospitals, et cetera. So that's what I meant.

Maybe that was implicit, but it wasn't explicit.

MR. LISK: That's a good point because it's not explicit in there, but that's important.

DR. ROWE: When you talk about the current GME program, and since we're going to try to come up with some reform or new approaches in directions for GME, I think you might have some of the demonstrations, like the New York state waiver described in here. That's not in the outline, but that seems to me to be an experience, or at least something that was --

MR. LISK: Yes, that's implied in terms of what I was thinking of in there because that's an important policy.

DR. ROWE: Policymakers are thinking about what are the options and which direction could we go in. There's one that's been developed and it should be included, I think.

I think where you talk about resident and physician supply and specialty distribution -- I'm going to get myself in trouble with my colleagues from academic

medicine here, but I would love to see -- it's really not just the number of doctors and their specialty in terms of their licensure, but it's their capacity to provide services that are needed by Medicare beneficiaries. That's what Medicare is about, and that brings me back to our first discussion yesterday morning about end-of-life care. I mean, this is the Medicare Trust Fund and it would be great to have a discussion. We may be beaten out of it, but it would be nice to have a discussion about whether it's appropriate.

Gail's point yesterday about we don't usually do it that way, I understand that.

DR. WILENSKY: No, I just meant it as -- if we want to go into the issue of tying, as an issue of accountability for example, the curriculum or the training program, that that's just something we ought to do in an explicit way because it is so unusual from the traditional--

DR. ROWE: I recognize it's a great departure and I recognize --

DR. WILENSKY: But I'm not objecting to it.

DR. ROWE: -- that I would make enemies here, but

I'm better off doing this than anybody else here. I just think we should ask the question in a specific section, is it not just the number of doctors in their specialty certification but it's their capacity to serve the needs of the patients and therefore should there be some capacity demonstrated or accountability?

And it may be that we want to pass that accountability off as a proxy to the ABIM or the RRC or somebody else. I don't have an opinion on that right now, but it just seems to me that we might bring it up, at least. It will no doubt generate comment and we'll get people's points of view.

DR. WILENSKY: What's the ABIM?

DR. ROWE: American Board of Internal Medicine.

DR. WILENSKY: And the RRC?

DR. ROWE: Residency Review Committee, RRC, the ones who approve the -- those are the ones to whom these people are accountable now in a way, these programs. That was another comment. You sort of say there's a lack of accountability.

I'd suggest that you entitle that section just

accountability and you describe it. They are accountable but they're just not accountable to the payer. Medicare pays but they're accountable to their licensing board or the Residency Review Committee or somebody else. But it's not like they're not accountable at all. They're accountable. It's just we want to, as a prudent purchaser, see that we're getting some response.

MR. GUTERMAN: Accountability was a term that was used by our mysterious panel and it's been used a lot in discussions, but actually part of -- and a lot of what's wrapped up in what's referred to as accountability is delineation of what Medicare is purchasing and what the best way might be to purchase that. That might be a more benign way of describing that. We're not accusing these hospitals of running willy-nilly, doing whatever they want to, regardless.

But if Medicare is implicitly paying for something, maybe some of these things should be better explicitly --

DR. ROWE: I believe that. But it's the way it's listed here, it appears --

MR. GUTERMAN: I understand that.

DR. ROWE: We have completed our considerations of that issue and made our decision and maybe we haven't.

DR. LONG: Jack, for we laypersons could you say a little more about what is in your head when you talk about the capacity to deliver care to this population?

DR. ROWE: Sure. I was just thinking that Medicare beneficiaries, excluding the end stage renal disease patients and those 5 million or so disabled individuals, represent largely older individuals. There are characteristics of their clinical needs and the care that should be provided to them of that population which are relevant to all physicians treating older persons. There are certain things about drugs affecting older people differently than younger people and physical changes in older people and their social setting and just how you deal with older people and their wound healing, regardless of the kind of surgeon you are.

And just the way you manage all the people. They have comorbidities, et cetera. There's a sort of body of information of geriatric medicine, kind of a core. One

would hope that any physician taking care of an older patient has some understanding of that. Yet a lot of training programs might not include anything about that.

DR. LONG: So we're talking about curriculum?

DR. ROWE: Yes, I think we're talking about supervision, curriculum, experience, testing.

I mean, the American Board of Internal Medicine, I understand, has included a large portion of this stuff in their exam to get certified. So you can't get certified as an internist in the United States without passing this exam. Now it has a lot of content on this stuff, 10 years ago it had none.

But I don't know how many other boards have done it, and I don't want to push it too hard. It just seems to me that the concept is it's not just the specialty and the number of doctors, but are they doctors who are attuned to this population?

There are other physicians here and I'd be interested in whether they buy this or not at all.

Just one or two others. The IMG issue, Craig, I think is a very interesting issue, but I just want to

clarify the two sides of the coin there without taking a stance. There is a side of the coin that says, international medical graduates compete with our graduates and we shouldn't be doing that, and it doesn't make sense, and if we have too many doctors in America maybe we should stop that inflow before we reduce American medical graduates and trainees.

The other side of the coin is less often stated as a national priority to help other developing countries because of our leadership role, and is more often stated that these international medical graduates are individuals who in many, not all cases but in many cases, fill the slots in teaching hospitals and areas that serve indigent populations, underserved populations in city hospitals. And that if there were no capacity for those individuals to come, American medical graduates might not be available or choose to take those positions, and those safety net hospitals would not be able to provide the needed services.

I'm not taking a position on either side of that, but I think that that paragraph should frame those two points of view.

I guess my last question had to do with the timetable. This report is going to be due, I gather, in August of next year and this is an important thing. It was mentioned by Gail, I think, yesterday or Murray, that we would probably hear a little bit about this at each meeting or something.

DR. ROSS: Or a lot.

DR. ROWE: Or a lot. I think this is a good example of a kind of thing that we shouldn't wait until it's all done before we see it. That was that discussion we had where we could get section A done, let's see section A, and that way we'll all feel less crunched next 4th of July.

DR. KEMPER: But we won't be meeting either. That's the other -- as this deadline approaches we won't be meeting.

DR. LEWERS: We're going to have to.

DR. ROSS: We have a blocked out a timetable that we can share with you.

DR. ROWE: But those are my comments. Thank you. I think this is really a terrific start.

MR. SHEA: I join in that. This is very helpful

for those of us who are not very well acquainted with this issue. Jack has made the point I wanted to raise more eloquently and in more detail than I could, but let me talk about it from a slightly different perspective. Jack, you spoke about the capacity to provide service. I want to put that in the context of, even if you believe, as I do, that what we're talking about here is a greater good -- albeit with a strong caveat that there are a lot of issues that need to be sorted out in that -- why aren't other people paying for the greater good?

DR. ROWE: Why are we the only ones paying for it.

MR. SHEA: Is the distribution of the dollars for this greater good going right? All those things I think need close examination. But if you believe that this is a greater good and probably proper funding, I do think it's entirely appropriate to ask whether or not Medicare is getting, for the monies it's putting in, the kind of preparation that allows the kinds of services that the beneficiaries need.

So I want to say I think this is a service to beneficiaries issue, in addition to all the other

perspectives that are very important to this. That's just a slightly different cut other than Jack had.

DR. ROWE: Just to give you a really gross example, if I could mention this one. A couple years ago, Congress decided to eliminate fellowship funding; that you could only get GME for X number of years after your medical degree. They eliminated a whole number of fellowships, and one of the fellowship fundings that they eliminated completely was geriatric medicine. And a number of us had to go to Congress and speak with Mr. Gingrich and with Ms. Johnson from Connecticut and others who wanted to do that, and the idea was, gee, we said, what better use of the Medicare trust fund than to train geriatricians which are documented to be in inadequate supply?

And that was the first sort of glimmer of matching the actual services to the needs, as opposed to just across the board changes. But there's a little bit of geriatrician in every doctor taking care of old people and we should make sure it's there.

MR. SHEA: Is there also a research analogy here? Is some of this money now -- let me just say it in regard to

the outline. Let's look at whether or not there's a relationship between targeting this money and the research that you could generate and most people would agree needs to be done in this field along the lines we were talking about yesterday.

DR. NEWHOUSE: Craig, let me start by saying, I'd like, if possible, to see more economic analysis in the report than I sense in the outline, and I'll be specific about a couple of areas. First of all, I think -- this doesn't flow directly out of economics but it leads on to something -- to separate and emphasize the differing rationales for the indirect medical education payment and the direct medical education payment.

And on the indirect side, the rationale is basically given that we have a prospective payment system for hospitals and we want a level playing field for teaching hospitals and non-teaching hospitals. And we have the empirical fact that teaching hospitals have higher costs per case, and that fact seems beyond dispute.

If it were the case, which it isn't, that all teaching hospitals were homogeneous and all non-teaching

hospitals were homogeneous, so they just had a different mean cost per case, I think we would have handled the indirect side of this quite differently. We would have handled it like we handle rural hospitals versus urban hospitals, and we'd have two payment rates; one payment rate for teaching hospitals and one payment rate for non-teaching hospitals. But we have something instead that looks more continuous, and as you have more interns and residents per bed, you have higher costs.

So the question then becomes, to what are those higher costs attributed? Here I think economics would suggest that it's not greater inefficiency of teaching hospitals. That they at least, if you didn't -- or let me put it another way. If they were all alike and you paid them a different rate, probably everything would be okay, because they would be -- they in effect are compared against every other hospital in those rates and they have incentives to be efficient.

So what are the costs due to? Well, we can't really disentangle it, but I think it's some combination of the following. One is that for a given case we may just

take care of the patient differently in teaching hospitals because the resident is there at 2:00 in the morning, the patient just has a different course of treatment than if the doctor has to be called at home and decides he or she doesn't want to come in and says something to the nurse and so forth. And those differences may be all to the benefit of the patient or not, but they're differences.

The second is that there potentially is some unmeasured case mix differences between teaching hospitals and non-teaching hospitals, teaching hospitals getting sicker patients. And the third possibility is that there's some subsidy of clinical research that's not being accounted for.

As I say, I don't think we're able to sort those out, but then when we get back to the rationale there's an issue of, should we be paying for those things or not? Should the Medicare program be paying for those things for its patients, and that we need to discuss. That's all on the indirect side.

On the direct side, then I think we get to the question of what are the issues with respect to the broader

workforce? Then the issue is, should the Medicare program be paying for those? So one of the conclusions I draw from this is that the rationale for Medicare payment is stronger on the indirect side than on the direct side, and that the direct payments, one can raise the issue about should they be coming out of general revenues or not.

The second broad area beyond the kind of indirect-direct difference is that -- where I'd like to see this go is I'd like to see some analysis of the incidence of these payments which will have to be, I think, primarily theoretical. But to what degree do these payments go to sustain salaries of residents, and to what degree do they go to adding to the numbers of residents, given how we've chosen to structure the payments, which is an additional payment per resident.

So those are two suggestions for what you might add here.

DR. LEWERS: Craig, this is obviously very ambitious. It also smacks of FLEXOR-II, and that took years to write. I think is going to take years to do.

One of my concerns that Jack brought up, and while

I sympathize with what he's saying, in particular in relationship to curriculum is that we have to be very careful that we don't get in an area that we don't have the expertise to really review. And I think that is an area that we don't have the expertise, while it is important. We started with the expert panel, some of their thoughts are excellent and I agree completely with them. But I'm very concerned about the depth of the workplan, and being able to actually accomplish it.

Just taking the IMG issue is a tremendous undertaking. It's not one that other people haven't been dealing with. And you get into workforce and the workforce issues are very difficult to come up with. We've got a lot of reports we can review, but all those reports started with a different basis and a different premise, so interpreting those is exceedingly difficult to do.

I guess while I commend you and I think this is a great start and needs to be done, I guess my concern is can we do it. And what I was wondering is if you could very briefly review the directives that we have. And I think we look at each of these and say, does it immediately go to the

directive? Not whether it needs to be done. It does. But is it something that we have to do, and how do we limit this report?

The other thing I think that we as a commission, and I think we have to start thinking in this direction, is we may well have to be very inventive -- and Murray, I think you're going to need to help us here -- on the process to achieve this. I'm not sure the process that we utilize for all of the other chapters and topics is going to be adequate for this. We at the AMA now have been dealing with many of these areas for years in trying to work through some of these, the workforce issues and things of this nature.

So as I read the outline, as I read the material that we've got, I agree completely with you, it is all relevant and all very important. But I'm not sure in the 11 months we have to achieve it, we can achieve it. So I think we need to think about how we're going to get this done. It needs to be done. How can we do it? Should we do this in part with some of the private sector, some of the schools, the academic world, the various groups involved in education helping us write this report, in a manner.

I mean, it would have to be our report, but I just don't see us being able to get everything that you have in that outline. I guess I'm asking you to take another look at it. I commend you, but I don't think you'd better plan any days off between now and then, and you'd better start adding some more people.

DR. ROSS: Let me see if I can raise your comfort level a little bit. First of all, we'll send you a timeline and some of the building blocks that underlie this outline in terms of how we've conceived of the projects that make this up. But second, in internal discussions we will have, at the moment, at least seven people involved. Not all on a full-time basis, but at least some part of seven different analysts on this. Craig we've already committed to 150 percent, but we are picking other pieces.

So don't be looking at this as a one or two-person project. Obviously this is a very ambitious outline. But remember too that it's an ambitious outline that reflects the mandate we were given in the Balanced Budget Act.

With respect to outsiders, no one has been shy about sharing and giving us input on this topic. But also

again as part of the formal consultation process, we will be circulating either draft pieces, or at one point a draft report for the interested parties to see. I think it's at that point we can count on a lot of help there.

DR. LEWERS: If I may just follow briefly. Stuart, do you want to comment on --

MR. GUTERMAN: Yes, if I can add also. Murray dealt with breadth maybe and I'll deal with depth. These issues are sort of bottomless, many of them, and what we intend to do is -- I think our mandate is to address many of them and to lay out directions to go to solve some of these problems. I don't think we're looking for -- certainly not the staff and not the Commission either, to solve all of these issues, but rather to indicate directions in which the Congress and we ourselves in the future ought to look in order to develop potential solutions for all of these things.

So you're right, if we were going to write the ultimate report. But I don't think we're going to write anything like FLEXOR-II. On Jack's issue, I think what we would end up with on the part of the Commission would be a

potential recommendation that Medicare ought to in making its medical education payments, presuming that you think they should continue to do that, require some sort of reporting on the distribution of specialty, or special training that is particularly tailored to the Medicare population. But not designing curricula for medical schools or anything like that, but just sort of a direction to go in.

DR. LEWERS: If I might follow just briefly. That's why I brought the issue up, because I heard Jack going a little further than I think we can go. I told him this privately before he left, so I'm not waiting until he left to say that. And maybe what you're going to provide us will make me a little more comfortable.

But I'll be very honest with you, seven people, that's not enough. It's all we've got maybe, but it is not going to be adequate, depending on the depth and what Stuart is talking about. Yes, we can raise a lot of questions. That's easy to do. But I've got a sense that what Congress asked us to do was to get a little more in depth than raising just issues.

So I'm anxious to get started with it. I'm anxious to work and be part of it. But I don't want us to think that we can do what I'm hearing a couple people say we're going to do in the depth of this outline.

DR. WILENSKY: Let me just carry this issue, particularly the curriculum, one step further because maybe we can have some discussion about how the commissioners who are still here feel about this.

It strikes me that one way we could deal with the issue of a type of accountability that Jack was raising is that if the justification that is raised for using Medicare monies to train physicians is that in the absence of such funding there might be an inadequate supply of physicians available for seniors, which is one of the rationales that's been used in the past, then the question might be, ought not the federal government, if it is relying on that as a justification, become more involved in making sure that the physicians trained are the physicians that Medicare seniors need.

That is not just in terms of the split between specialists and primary care physicians, or among

specialists, but making sure that in areas, particularly if they haven't seemed to get brought forth by the market, like geriatricians, that people with the training necessary to provide services for seniors are available and that this would be a quid pro quo for such amounts of money. Without getting into what this curriculum should look like, but saying that if that's the justification then it might follow that this is an appropriate role for those who receive payment, and not attempt in any way, for this commission for sure, to lay out specifically how you would go about doing that.

But that would give a very specific direction, for example, that is not present. It is not a different -- I'm not suggesting that we adopt this as a policy, but it would strike me how we could respond to what Jack has raised, but still acknowledge what I think is correct from your point of view, that we aren't going to be in a position to actually go about and say that the curriculum ought to include whatever. But just to say that this now would become a federal responsibility, again on the justification that the reason you're doing this is you don't think you'll see

enough physicians to take care of seniors. That's why it ought to be a Medicare funding strategy.

MR. GUTERMAN: Also I don't mean to imply that we would consider raising questions would be enough. But setting directions is quite different than raising questions. I think we can identify a number of issues on which the Commission would be prepared, we think, to make specific recommendations, if so inclined. And on many of these other issues setting broad outlines for the direction policy should go in would be a major improvement over the status quo.

DR. LEWERS: Just briefly. I agree with that and I agree with you, Gail. But about the only ones that don't care of the Medicare population are pediatricians. So I don't know how you narrow that. If we try to get into that, suddenly we've got, I do this, I do that, I take care of their toenails. So I fully understand where you're headed, that we're not going to be in the depth we'd like to perhaps ultimately be.

But I guess what I'm saying is that asking Craig and Murray and all to take a look at this and make sure that

everything that's in there is something we have to do. Let's get that done and done well, and then attack the other areas that we think should be attacked or questioned. I guess that's my concern. I don't want to see us put a report out that doesn't really have the quality that we all want and we're used to. And I think if we bite off too much, we can do that easily.

DR. WILENSKY: Peter?

DR. KEMPER: I had two comments. The first one is, I think it would useful to see a little more emphasis on regional distribution. Not just the quantity in a sense, but if there were quality indicators, that would be even better. Just from the perspective of the potential for academic health centers to increase quality of care, both through the services that they provide and the cutting edge care, but also through the training. So that a real geographic imbalance could be an issue, and how the payment policy affects that would be an issue.

The second comment has to do with when you're talking about the policy reform and the objectives. You emphasize the workforce financing, but you don't talk much

about the other objectives that the panel talked about, the sort of multi-dimensional objectives including innovation, standby costs, research, and so on. It seems to me that's a real fundamental issue that we have to somehow sort out pretty early is how we feel about that very broad set of competing objectives before you can go anywhere when you're suggesting directions.

I don't know how you come to a judgment. It seems to me that's almost a political judgment that's tough to come to through analysis.

DR. CURRERI: I probably want to add on to what Ted said. When I first read this outline it scared me to death, to be honest with you. And the reason for it is because it seems to me we should have been three-fourths of the way through this outline because going to a section four is really tough. I can tell you when we did this on PPRC, you not only have the analysis that has to be done, but then you have to look at the political feasibility of doing this as well as the financial feasibility, as well as the resistance from various groups that might be asked to contribute monies, and so forth and so on.

Then after I looked back and went over it again, I felt a little better about it, because I really think we've done one and two and most of that appears in previous reports. But I think that, quite honestly, to go from three where we're putting down all the facts and doing the analysis, to four, is going to take several months. And I would really urge you --

I don't know what your timeline is, but my timeline if I were putting the timeline out, would be to finish three as much as possible within the next 60 days. Because I think to go from three to four and make rational, reasonable -- and you're going to need to have more information. Once you do the analysis and you see which way looks potentially a better way to reform the policies, then you're going to have to see is that really possible or not, and you're going to have to collect a whole new set of data. And that's going to take as -- it may not take years, but it's going to take several months.

So I just think we need to push forward as fast as we can on the analysis part so we can know what we're going to have to look to to get to policy changes.

DR. LONG: I want to talk just a second about physician substitutes and the workforce issues involved and also how that brings us back full circle to yesterday morning. But if we're talking narrowly about teaching hospitals and payments by Medicare associated with the training of physicians, those elements of the caregiving system are clearly not either the historic growth areas or the areas that will be moving to into the future.

I think if you look at health workforce generally over the last decade and say, who are the actual caregivers laying on hands of the Medicare population, the growth there -- I don't have the actual numbers or the percentages, but the growth there would seem to be not in the area of M.D.'s and D.O.'s but other professional caregivers. And certainly what we heard yesterday morning about care at the end of life and the changing processes of dying it certainly didn't sound to me like we were talking about having a physician in every pot.

We were talking about having a whole variety of different kinds of caregivers that I think is probably far richer than simply nurse practitioners and physician

assistants. It involves not only other personnel but also new technology and other things that are substituting for perhaps what physicians did historically.

Now this quickly gets us back into the scary area of, what can we possibly really do within the constraints, the timeframe, the congressional charge, et cetera.

But if the real focus here is more than simply paying for the education of physicians and ensuring the survival of the safety net hospitals, the teaching hospitals, particularly in urban areas, but really talking about in the broader language of congressional language of Medicare payment policies and other federal policies that somehow affect the way in which we have a cadre of personnel that we really want to deliver care to this population, then I think perhaps some additional emphasis on the evolution of a broader range of caregivers needs to be included.

MR. MacBAIN: I think as we get into this part three section where is envisioned a lot of discussion and some pretty thorny issues, if we try to focus a lot on that without having a sense of where we want to come out at the other end of the maze, we'll never get out of it. We can

spend a lot of time simply talking about the fascinating implications of various approaches to IME.

I guess I look at this more as an iterative process, to try to get as quickly through the factual, just sort of listing all the information we need to get some broad consensus on where we want to come out, where we actually are trying to get. If we have a sense of what our overall objectives are, recognizing that we're going to iterate through that a few times.

But we could be like a bunch of people trying to figure out the best route on a map and if we don't know what city we want to get to, we're going to get caught up in the scenic routes. I don't know if I'm putting it too clearly, but I really have a sense that our discussion is going to be a lot clearer if we can arrive at some early consensus on some of the objectives we're trying to achieve. So rather than a clear, here's section three, we're going to go through all of this for three months and then we're going to focus on section four, to try to iterate through this whole last half of the process several times.

MR. LISK: In part in how we're structuring the

discussions we'll be trying to attempt that. It's not presenting just -- we'll probably try to present some -- provide you, and we may not present it -- some of the basic background information at the next meeting in terms of what comes in terms of the history and the current payment type of system in terms of the current payment rules. But approaching it by talking about it at one meeting in terms of the physician, some of the physician issues, and not talking about all the issues all at once, but devoting specific meetings talking about specific areas.

DR. CURRERI: Haven't we had all that background material?

MR. LISK: Yes, you have.

DR. CURRERI: Then I don't see any need to do it again.

MR. LISK: We need to do it, and I don't think we probably would present that. We might include it in your briefing materials just for you to remember, but I don't have an intention really of rehashing all that. We have presented that before and I don't think it's specifically necessary to re-present that information, and for your

discussion. So your discussion could be more focused on identifying some of the issues you want to focus on for development of recommendations and such, too, and objectives.

DR. WILENSKY: We just had a side discussion of something we may or may not want to get into is, in thinking about how to try to make this discussion relevant for allowance of some sort of Medicare reform, whether we might want to have at least a small section. I was thinking about the distinction Joe had made between the indirect medical education and the direct medical education, and the different justifications you use for each of those components.

If there were to be changes in Medicare toward more of premium support systems, for example, as one of the options that gets considered, what that would mean for indirect medical education. Whether you would want to set aside a trust fund, the way they're proposing now, whether you'd want to assume plans would get the money back or whatever.

It is somewhat of a second level issue, but to the

extent that the Congress is thinking about those broader changes in Medicare, to at least indicate how whatever we're saying about what the future of indirect medical education or the different cost structure might be, how that could play out with a slightly altered or a substantially altered Medicare system.

DR. NEWHOUSE: There's the here and now issue of how to allocate the existing trust fund --

DR. WILENSKY: Right, with the growth of capitation.

DR. NEWHOUSE: -- on the Medicare+Choice side that needs to be considered here as well, I would think, unless the Congress has told us they don't want us to do that.

DR. WILENSKY: Yes, and this is just the extension of, if you have growth that puts the Medicare+Choice to 25 percent of the Medicare population in 10 years, or whatever it actually turns out to be, what does that now mean in terms of your indirect medical education payments? So we really do have to deal with it. And even more so if it turns out that we move to a different Medicare structure.

DR. CURRERI: There's a lot of information I think

we need to make those decisions. I don't have the faintest idea what it is, what the answers are, until we get that information I think, which is why I'm urging the analysis to go --

DR. WILENSKY: Murray has been, and for our October meeting we will focus on a time schedule to try to provide some increased level of comfort. Level of comfort may be too strong, but to get a little better sense about where we think, or how long it will take us to get to several of the segment points that we've talked about here.

Are there any other issues that people -- Stuart?

MR. GUTERMAN: Also in response to that, let me point out -- it's something that staff occasionally finds itself in a position of doing -- pointing out that the amount of information that, number one, is available, and number two, that you actually need to make some of these decisions may be less than you think. Because many of these things really are a matter of how you evaluate the structure of the Medicare program, the role of the program, what we think the Medicare program is buying now.

We can provide some information on a lot of that

stuff, but the bottom line is how the Commission thinks the Medicare program ought to approach these issues frequently. So don't look for these numbers to make the decisions for you.

DR. WILENSKY: Right, only the implications.

Any further comment?

Friday afternoon may become graduate medical education discussions from now until our report is due. We will clearly need to have a block of time each meeting to make sure we go through progress or information on another area.

Thank you.

DR. LEWERS: Are you planning on blocking out a July meeting?

DR. WILENSKY: We'll definitely have our June because we'll have the retreat. We can use a portion of the time at the retreat to discuss this issue. That's tentatively scheduled in mid-June. And we may need one last meeting in early July and try to catch people before it goes to the printer.

DR. ROSS: Although just given the time frame if

we have a mid-June retreat and a first week of August deadline I'd like to approve the final report in June.

DR. WILENSKY: Yes, that would be better. We could presumably have a meeting after the fourth if we needed it to try to resolve some outstanding issues and still make our August deadline.

We are going to break for lunch now.

MR. MacBAIN: Let me just reiterate one point I made earlier, because this time frame is going to get awfully tight, awfully fast. And that's, as individual sections get done, e-mail them to us, give us a chance to get back, circulate comments. Use every tool you've got to get information back and forth as quickly as possible.

DR. WILENSKY: It's also going to get tight when you remember we still are going to have a March and June report. So this is not the only issue.

DR. LEWERS: That's what we're worried about.

DR. WILENSKY: We are going to break until 1:30, when we will resume with our discussion on risk adjustment.

[Whereupon, at 12:49 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:42 p.m.]

DR. WILENSKY: We're ready to start. For those of you who came expecting to hear a discussion on graduate medical education, in order to accommodate commissioners' requests we rearranged the agenda late last evening. In the future, we will be distributing any changes in the agenda both to all of the other commissioners and making them easily, publicly available to people who like to attend our meetings. We probably caused at least as much disruption

and confusion as we tried to prevent by accommodating the request. From here on out we will have cleared the schedules with the commissioners a couple of weeks beforehand.

If there is an issue, it needs to be resolved at least a couple of weeks beforehand so we can make sure that it does not cause other difficulties. And we will also make sure that the schedule is available on the web site, so any of you who are planning to come, if you have any question about whether there might be a change in the organization of topics, you'll be able to get confirmation of the schedule on our web site.

We will be having our meetings generally in the time frame that you are seeing them. That is, starting on Thursday morning and going until about 3:00 on Friday. But again, that information will be available a couple of weeks in advance, if not more so, so that you'll be able to see both the times and the distribution of topics.

We are now turning to one of the topics that we have devoted a substantial amount of time in the past, but we'll clearly be devoting time in the future as well because

of its complexity and also because of its proximity now to a legislative time frame. That's of risk adjustment. We welcome Julian to this area, and also Dan Zabinski, both to the Commission meeting and to this area, and look forward to your helping us sort out the issues that we have to deal with in risk adjustment.

Julian and Dan?

MR. PETTENGILL: We look forward to the challenge. As it happens, we were going to give you an update regarding HCFA's plans for the risk adjustment system they have to implement in January 1st, 2000. By coincidence, HCFA published on September 8th, the notice describing the proposal they have in mind and then held a meeting all day yesterday to give people more information about the proposal. Since they only used eight pages in the Federal Register, they couldn't have described it all.

But before we get to that -- and Dan and I are going to take you through the pieces of the proposal, but I'd like to start with the conceptual framework for risk adjustment, just to make sure we're all understanding this the same way.

Basically, the discussions of risk adjustment usually start with the problem of selection. But it's often, I think, useful to think about this as a part of the administered pricing system. In the Medicare+Choice program, HCFA has the problem is setting rates for the plans, for covering a person for a year.

Conceptually, HCFA's objective is to set fair payment rates. Meaning that the rates will cover the costs expected to be incurred by an efficient plan for beneficiaries with different characteristics. Sound familiar?

The Medicare+Choice rates determined by multiplying the base amount in the county rate book by a relative weight, which currently represents the beneficiary's demographic risk score. The relative weight is the beneficiary's risk score representing the expected relative costliness of covering or spending, given the beneficiary's characteristics.

Again, as we were talking this morning, if you do this right you get fair rates which reduce the rewards that plans get for selection, and at the same time provide

sufficient resources so that plans will be willing to take on beneficiaries who are relatively ill.

The problem is that the current risk adjustment system based on beneficiary's demographic characteristics is really weak, and Congress was trying to address that problem in requiring the Department or HCFA to implement a new system beginning January 1, 2000.

Now the timetable for doing this is extremely tight, to say the least. In a sense, the fact that it's tight for HCFA means in a way that it's tight for us, too. The comments on the proposed notice are due October 6th, which is less than three weeks from now. Then in January, the 15th of January, HCFA has to publish the 45-day notice which announces changes in the assumptions and methods they're going to use to set the rates for 2000.

We learned yesterday that -- I thought that implies that they have to have the risk adjustment method they're going to use essentially set in stone by the end of November. But they told us yesterday that they plan to have that completely determined by the end of October. So they are really hurtling toward the goal here.

Then on March 1st they have to announce the rates for calendar year 2000, and at the same time they have to file a report with Congress that explains the risk adjustment system they're using and incorporates an independent evaluation -- an evaluation of the risk adjustment system by an independent actuary.

Now the next overhead outlines the main components of the proposal of which the first three are the most important in the very short run. The plan calls for a risk measure based on health status and demographic characteristics. The demographic characteristics will be similar to those that are used in the current system like age and sex and eligibility for Medicaid benefits. The health status part of it is a modified version of the principal inpatient diagnostic cost groups, PIP DCGs.

Risk scores are intended to measure expected relative costliness in the forthcoming year based on age -- this is the way I think this will work. You can know the enrollee's sex and age for the forthcoming year, because one doesn't change and the other changes in a perfectly predictable way.

[Laughter.]

MR. PETTENGILL: What you can't know is whether during the previous year the person was eligible for any period of time for Medicaid, and that's one of the factors that affect the risk score. And the reason you can't know that is that HCFA won't have all the data for the full preceding calendar year at the time they have to set the initial payment for that enrollee. Similarly, you can't know whether the person was hospitalized during the previous year and therefore placed in a DCG. Again, for the same reason, they won't have all of the information available at the start of the calendar year.

So I think the way it will work is the age and sex will be based on what the enrollee's age and sex is in the current year, the year of payment. And the diagnoses and eligibility for Medicaid will be based on what went on in the prior year. Then you'll have this issue of whether to set interim rates and then adjust retroactively as the rest of the calendar year's data comes in, or not. We'll come back to that a bit later.

It's a prospective model. It attempts to predict

what spending will be for an enrollee in the forthcoming year, given events that did or didn't happen in the preceding year.

The third element is the so-called rescaling factor. Substituting the new risk scoring system means that you'll be using risk scores that are inconsistent with those that were used to standardize the county rates in the county rate book. And if you didn't correct that inconsistency, then what would happen is that enrollees in one county would be overpaid and in another county they're be underpaid. You'd have all these payment errors going on which would effect plans according to which counties they serve. I'll come back and explain how the rescaling works, or at least conceptually how it works and show you an example that makes it clear why they need to do it.

In the end you'll have a payment rate then that is equal to the county rate book amount multiplied by a rescaling factor for the county and then multiplied by the enrollee's new risk score. That will be the payment for the enrollee during the year.

The refinement plan that was the least talked

about -- there was a little bit of discussion of it yesterday. The part that's in the notice is very brief and very terse. It's clear that HCFA intends to expand the PIP DCGs to take into account encounter data that covers physician services, hospital outpatient, skilled nursing facilities, and home health, at a minimum, and perhaps more. I'm not sure what that more might be and they didn't say.

But they also do not plan to begin collecting that data until at least next October; October 1, '99. And they say that they will need to collect it for about three years before they will be ready to make modifications to the risk adjustment scoring system; that is, the DCGs, or something similar. So implementation couldn't possibly occur earlier than about 2003.

DR. WILENSKY: Implementation of the refined --

MR. PETTENGILL: Of a refinement, right. In the meantime, everything will be based on the encounter data that Medicare+Choice plans are now submitting, which had originally been scheduled -- the submission had been scheduled to be complete today. But they had some

difficulties in getting it all in, so they have about 40 percent of it, 45 percent of it is in.

MR. ZABINSKI: Something like that.

MR. PETTENGILL: And they've extended the deadline until October 16th.

MR. ZABINSKI: October 16th. Four weeks from today.

MR. PETTENGILL: So they won't have all of the encounter data until a month from now. Then they will have about two months to process it and figure out what the rate book will look like for 2000.

Now Dan's going to take you through the details of the risk categories they're using here. This is like what we were talking about this morning. You have a set of categories and a set of weights to measure the risk. First he's going to talk about the categories, and then the weights, and so on, and then I'll come back a bit later.

MR. ZABINSKI: What this diagram illustrates is the fact that there are many more variable categories in the new risk adjustment system than there are in the current system. I'll just walk you through the diagram. In the

very left-hand column you have the variables that are used in the risk adjustment system. There's age, sex, health status, which is only going to be used in the new system and that's just the diagnostic cost groups, Medicaid, institutional status. And in the new system there will be a variable for the aged that says whether they were -- before being eligible on the basis of age whether they were eligible for Medicare on the basis of a disability.

Then we divide the variables into two groups, those for the aged and those for the disabled, because there's a slight difference between the two variables that are used for those two groups. Then within the aged and within the disabled we divide the variables into those for the current system and those for the new system.

And what the numbers mean, for example, the 10 for the aged in the current system on age, sex, it just tells us that there are 10 categories in age, sex for the aged in the current system. And the dashed lines tell us that that variable is not used in that particular system. For example, health status is not a variable for the aged in the current system.

If you take the product of all the numbers in each column you get the total in the bottom. That tells us the total number of categories upon which risk scores are based in the system. For example, for the aged in the current system there are a total of 40 categories. Likewise for the disabled in the current system there are 40 categories, for a total of 80 categories right now. While in the new system the aged have a lot more categories than they currently do -- 560 -- the disabled have 200 in the new system, for a grand total of 760 categories in the new system.

Now the DCGs are one of the variables used to determine risk scores in the new system, and I'll walk you through how HCFA is determining DCGs. First of all, it's a three-step process. They sort the ICD-9-CM codes into broader categories called DxGroups with the idea of creating clinically homogeneous groups within the DxGroups. Then they take the fee-for-service beneficiaries in the 5 percent Medicare claims file and place them into DxGroups based upon their 1995 principal inpatient diagnosis for each hospital stay that they had in that year.

Then they form DCGs by collapsing DxGroups in the

following way. Within each DxGroup they take the mean of the total 1996 spending for the beneficiaries that fit into that DxGroup. Then based upon that mean they fit the DxGroup into a predetermined range of spending, and that's what a DCG is. It's just a predetermined range of spending that has been determined ahead of time. That's a little redundant.

Basically I think one thing they were trying to do was get enough beneficiaries within a DCG so that they can obtain reliable statistics. They're going to run some regressions off these things so they need an adequate sample size to obtain reliable statistics.

Now in HCFA's Federal Register report they said that these first two steps resulted in excess of 20 DCGs. But as you saw in the previous slide, there are only 10 DCGs that are going to be used. And they got down to the 10 by doing the third step. They had a panel of physicians review each DxGroup and then they assigned some of those DxGroups that they determined to have highly discretionary inpatient hospital stays into what's called default DCG, which is simply the DCG that includes, amongst other things, the

DxGroup for he beneficiaries that have no 1995 inpatient hospital stay.

Now once again, the DCGs are used to determine risk scores for beneficiaries, and the method by which risk scores are determined is as follows. Once again, they use fee-for-service beneficiaries from the 5 percent Medicare claims sample to do the analysis, and the data that they pull off from the claims file are their 1995 principal inpatient hospitals stays to establish what the beneficiary's DCGs are, their 1996 total spending, and their 1996 demographics that match up with the variables that you saw on the first slide that I showed.

Then they take the beneficiaries and they assign them to one of the 760 categories that I mentioned on the first slide, based upon what their characteristics are. Then they use that data to perform a regression analysis, and the results of that regression are used to estimate the expected incremental spending for each possible attribute that a beneficiary can have.

Then those results can be used to determine a beneficiary's expected total spending by taking the sum of

the incremental spending associated with each of the beneficiary's attributes. Finally, the risk score can be determined by dividing that expected total spending by the national average total expected spending.

Now we don't have an overhead for this, but at the meeting yesterday at HCFA they ran through an example that really shows how sensitive the risk scores are to the DCGs to which a beneficiary can belong to. For example, the first thing they showed was that for a male who's 75 to 79-years-old that's not in Medicaid nor was ever receiving disability benefits, and also they had no inpatient stay in the previous year, that their risk score would be .89.

However, if that same beneficiary had a hospitalization due to a kidney infection in the previous year, their risk score would be about 1.99, which is about 2.3 times as large as risk score if they had no inpatient hospital stay. That means that their payment due to that inpatient stay would be 2.3 times higher than what it would be without it.

Moreover, they went through an even more extreme example where they said, now suppose that person has

something more serious, congestive heart failure in the previous year? Then their risk score would go up even higher to 3.7. So once again, the risk scores are very sensitive to the DCGs to which a person can belong.

Now the risk score range, it seems reasonable that it will be much wider in the new system relative to what it would be in the current system. Using some information that Julian and I had at our disposal, we found that in the current system a range of risk scores for 1999 will be something like .6 at the low end up to 2.2 at the high end, which is taking the ratio of the high score to the low score there. That's about 3.8. But in the new system in 1999, the risk score range would be something like .2 or .25 at the low end up to about 7.7 at the high end. And that's a ratio of something like 35 to one.

Julian, is going to finish the talk.

DR. CURRERI: Just out of curiosity, what disease or classification would rank as 7.7? It must be near dead.

MR. ZABINSKI: First of all, the classification would be for the second highest male. He'd have to be Medicaid eligible, previously eligible to a disability, and

-- the DCG would be number 29, and that adds about $29,000 to the payment. I'm not sure what's in that category. I think it's something like --

MR. PETTENGILL: Not $29,000. You take the sum, add it up, and divide by the national average, and that gives you that relative weight of 7.7, which would be multiplied by the applicable amount in the county rate book, which is the monthly amount.

MR. ZABINSKI: That's what I meant.

[Laughter.]

MR. PETTENGILL: Let's talk about rescaling. What's going on here -- actually, the more I think about it, the more I think this is a little misleading.

But the need for rescaling arises for two reasons. One is that the new risk scores are inconsistent with those used to determine the county rates in the county rate book. As I said before, if you don't correct it you get overpayments in some counties and underpayments in others. The second reason is that Congress wanted to ensure that the county rates would always go up by at least 2 percent. So they wrote into the law how the rates have to be calculated.

And that part of the law doesn't say anything about restandardizing the rates for risk adjustment.

So you can't simply go back and say, okay, we're going to recalculate the rate book to reflect the use of the new risk scores. Instead, what you have to do is create this separate factor which would be applied to the rate book amount to correct it. That's what this rescaling factor is.

Now if you look at the next overhead I think it becomes reasonably clear what the rescaling does. Now if you take County A, just suppose that 95 percent of the projected fee-for-service spending per capita in the base year, which was 1997, was $5,000. Now we're going to ignore how the rates are updated because that's from year to year, because that's a separate problem not directly involved with this.

The rate book amount is what Medicare would pay in County A for a standard beneficiary. And a standard beneficiary means somebody with a national average demographic factor, which is one. So to get that amount for this county, you have to take the average per capita spending and divide it by the average demographic factor in

this county, which is 1.1. When you do that, you get a rate of $4,545. That's the amount that Medicare would pay for a national average beneficiary if they were enrolled from this county. That's what the rate book means.

So if you wanted to pay for the average beneficiary in this county, you would be paying $4,545 multiplied by 1.1, which is the current risk score, and you'd get $5,000, which is exactly what you should pay.

DR. NEWHOUSE: You're paying $5,000 for somebody with the characteristics of 1.1?

MR. PETTENGILL: Yes.

DR. NEWHOUSE: That's the average fee-for-service beneficiary.

MR. PETTENGILL: Yes. If the average fee-for-service beneficiary living in this county enrolled in a risk plan, you would want to pay $5,000 for them.

Under the new risk scoring system, the average fee-for-service beneficiary has a risk score of 1.3. That's even though the national average for the new risk scores is one. It has the same scale. So if you wanted to pay the right amount now for the average beneficiary living in this

county you couldn't multiple the 1.3 times the $4,545. You'd get the wrong number. It would be almost $6,000.

So what you have to do is rescale the rate book amount. The way you do that is by dividing the old average risk score in the county, 1.1, by the new average risk score in the county, which is 1.3. And when you do that it gives you -- and then multiply $4,545 by the rescaling factor, and then by 1.3, you get the same $5,000.

MR. MacBAIN: Clarification here. The old risk score is based on just the demographic factors?

MR. PETTENGILL: That's right.

MR. MacBAIN: The average age, sex, et cetera, mix of the county?

MR. PETTENGILL: Right.

MR. MacBAIN: The new score is based on those factors plus all the DCG information for the county?

MR. PETTENGILL: The DCGs.

MR. MacBAIN: All of which goes back to, or that part goes back to the 5 percent sample?

MR. PETTENGILL: Right.

MR. MacBAIN: How good is the 5 percent sample

when you get down to the individual county level?

MR. PETTENGILL: That's a good question. It has 1.4 million beneficiaries, so that's a fair amount. I'm sure for some counties it's not very good.

DR. NEWHOUSE: Are they still smoothing it over five years then?

MR. PETTENGILL: No, they used to do the smoothing over five years with respect to what was called the average geographic adjustment, which is a different animal. That's the one that brings the USPCC to the AAPCC.

DR. NEWHOUSE: So this is just one year's worth of data for a county, the standardization factor?

MR. PETTENGILL: This is two.

DR. CURRERI: It has to be two, isn't it?

MR. PETTENGILL: I'm sure that in some counties you have relatively few beneficiaries. And of course, this is a 5 percent sample, so you're going to have very few --

MR. MacBAIN: Yes, that's what I was wondering. If you've got a rural county that happens to have a lot of risk plan enrollees, for instance, you could end up with a lot of volatility year to year and none of it representing

the true risk base.

MR. PETTENGILL: That's a good point.

DR. WILENSKY: The volatility in fee-for-service?

MR. MacBAIN: Yes, which then translates into volatility in the payment rates, and you could have either windfalls or --

DR. WILENSKY: Like in probably the counties around Portland, Oregon.

DR. NEWHOUSE: But even with the five-year smoothing, we have tables in the ProPAC reports of the volatility showing like 20-plus, and one case was 40 percent change year to year, even with five-year smoothing.

MR. PETTENGILL: Right. That's a real potential problem here.

Now this rescaling factor is going to be different for every county because the averages, average risk scores under the old and the new systems are going to be different, which means sometimes it's going to be a factor bigger than one, in effect raising the rate, and in other cases it's going to reduce it, as it does here.

The rate book amount won't change. HCFA will

publish a rate book that reflects the rules for setting the rates, the blended amount, the minimum payment, and the floor, and budget neutrality each year. Then it will publish also a rescaling factor for each county for each year.

It's also worth noting that the rate books for -- right now the rate books separate Part A and Part B. There's a separate risk score for Part A and Part B, and there are separate rate books for aged and disabled. That will no longer be the case. Under the new scoring system they will collapse the aged and disabled rate books, and Part A and Part B will also be collapsed. So you will have essentially a single number as the rate book amount.

DR. NEWHOUSE: What's the age groupings then in the under 65?

MR. PETTENGILL: The age groupings for under 65? The lowest one is zero to 34, I think, and then it goes up in increments to 65. They've dropped institutionalization as well, arguing that the DCGs represent health status much better than institutionalization did, and Medicaid eligibility for any time period during a previous year,

because they've found that's what works. And it doesn't seem to make any difference whether you focus on people who are eligible for Medicaid because of poverty or those who -- whether you make the distinction between the QMBs and SLIMBs and so on doesn't seem to matter very much.

DR. CURRERI: Isn't there a problem -- I think we saw data that the disabled spend, on average, only 80 percent or 84 percent of what the elderly do. And by collapsing these, isn't there going to be a disproportionate effect in those counties that have lots of disabled where they're going to have a windfall?

MR. PETTENGILL: Maybe collapsing isn't the right word. Disabled people will end up in different cells, different risk scoring categories than aged people do, in any case. In addition to that, for the aged they have this variable that indicates whether the aged person was previously qualified for Medicare benefits on the basis of disability before they aged in.

MR. MacBAIN: But that adjustment only occurs two years following the year in which they're admitted to a hospital. So it's no longer a permanent adjustment because

of institutional status.

MR. ZABINSKI: That's right.

MR. MacBAIN: Unless they get readmitted every year.

MR. ZABINSKI: It's a one-year bump.

MR. PETTENGILL: Right. It has a duration of one year, too.

DR. WILENSKY: Now this is to get a factor that is used -- the risk factor for the county. But the actual payment then would be dependent on the age and sex and the risk factor according to who actually went into the plan?

MR. PETTENGILL: Right. Yes, the actual payment rates of the plan is the rate book amount multiplied by the rescaling factor and then multiplied by the risk score for the beneficiary, which is based on all the beneficiary's attributes.

DR. ROSS: And the rescaling factor will be recalculated each year?

MR. PETTENGILL: Yes. I was going to say, if you had a suspicion that it wasn't this simple, you were absolutely right. It's nothing like this simple. In fact,

according to the actuaries, what they're going to do is compute two rate books. One of them is going to be the rate book based on the rules in the law about updating rates, and the old risk scores. And side by side with that they're going to compute a rate book that is based on the new risk scoring system, and the same other rules. Then the county rescaling factor for each county will be the ratio of the rate book amounts.

DR. ROSS: And only in the first year will it be based on the distribution of fee-for-service?

MR. PETTENGILL: No, it will always be based on fee-for-service into the foreseeable future, although eventually -- I mean, at some point this is highly problematic.

DR. WILENSKY: This is what?

MR. PETTENGILL: Problematic. This is a big problem. At some point you'd love to get away from this system and say, let's cut things right here and switch over and go from there. But that's not allowed in the law.

MR. MacBAIN: With health plans starting to report encounter and claim data, HCFA will be able to amass a

managed care equivalent of fee-for-service database which they could then re-price and recreate the equivalent of, using a managed care sample.

MR. PETTENGILL: Yes.

MR. MacBAIN: Are they planning to do that?

MR. PETTENGILL: They are certainly aware that it is going to be increasingly difficult to have rates that are based on fee-for-service baseline forever, and I'm sure that they're thinking about how to make -- what kind of conversion to ask Congress for to get to a baseline that reflects what managed care entities do.

DR. ROSS: Julian, there's two issues here. One is the coefficients and one is the weights. In year one you're using a fee-for-service population -- you have to -- for both of them. Then the question is, in year two you still need to stick with -- do you retain the old coefficients but plug in the new weights, because now you have encounter data from the Medicare+Choice plans to calculate the county average risk score?

MR. PETTENGILL: If by coefficients you mean the relative values --

DR. ROSS: The incremental costs.

MR. PETTENGILL: -- assigned to the attributes, yes. Those will be based on fee-for-service. They'll continue to be based on fee-for-service.

DR. ROSS: But you'll plug in the whole county population, not just the fee-for-service in years two and --

MR. PETTENGILL: I don't think so, because the AAPCCs in the base subtracted out the HMO costs, and were divided by the demographic cost factors for the fee-for-service population in the county.

DR. NEWHOUSE: You wouldn't have to have two rate books unless you were going to --

DR. CURRERI: The law makes them have two rate books.

DR. NEWHOUSE: But only because you're computing off fee-for-service.

MR. PETTENGILL: Right.

MR. MacBAIN: That's a good point. You have to go through all of this stuff because you're ultimately applying it to an AAPCC that's based on the fee-for-service data. So when you introduce managed care data, you're mixing two

different sources and you can't take the managed care frequency data and apply it to a fee-for-service AAPCC and come up with something sensible. So I think the fact that the AAPCC is baked in at a lower stratum makes the rest of the stuff pretty much have to follow the fee-for-service line.

MR. PETTENGILL: Scary, isn't it?

DR. LONG: Julian, a question about -- again I'm not sure I'm clear on the disability cells now for the aged. If I am in Medicare by virtue of being disabled at the age of 64, when I turn 65 I'm now aged, and it used to be we ignored disability.

MR. PETTENGILL: Right.

DR. LONG: But now we're not going to ignore disability forever, for two years?

MR. PETTENGILL: No, forever. If you were eligible for Medicare on the basis of disability prior to aging in then you get this factor that is added for the rest of your life.

DR. LONG: So 72-year-old males, otherwise identical except that one became paraplegic at 63 and the

other one at 68, are going to be in different cells forever?

MR. PETTENGILL: Right. Well, nothing is forever.

DR. LONG: All other things being equal.

MR. PETTENGILL: Pending refinement. Because these things are all estimated by regression weights. If you change the definition of the health status measure, it's going to alter the coefficients you get for some of the other variables as well.

DR. NEWHOUSE: Could I ask you a question on that? You keep saying regression. Is that just an additive model?

MR. PETTENGILL: Yes.

DR. NEWHOUSE: Or does it have all the higher order interactions in it?

MR. PETTENGILL: No, I don't believe they used any interactions. They've got 37 variables. I don't think they had any interactions in it. But I couldn't swear to that. They described it, but it's not the description you would get if you were talking to the person actually doing the work.

Now the other thing you want to note about the rescaling factors is that in the aggregate they don't really

have any effect. They won't alter, by themselves, spending in the aggregate. They will affect the amount that is paid in each county, and they will affect the amounts that plans receive, depending on which counties they serve.

Those changes in the payment amounts may cause plans to alter their behavior, suspending marketing, or getting out of a county altogether, or whatever they choose to do, or attempting to accelerate marketing because it looks like a relatively favorable situation. That may affect total spending ultimately, but it will be only by that kind of indirection that it occurs.

So between rescaling and the adoption of risk scores that are more sensitive to the risk level of the beneficiary there's the potential here for fairly strong redistributive effects among plans. We evaluated the current range of monthly payments at the USPCC -- in other words, ignoring the variation in county rates across counties -- and with the current weights the values range from $282 a month to $1,021 a month. With the new system they range from $109 to $3,560. Now that's at the extreme.

One of the other things you should know about

these DCGs is that when you get to the really high end there aren't very many people in those categories. In fact, in the DCGs altogether you're only classifying about 12 percent of the --

DR. WILENSKY: Excuse me, what was the range that you talked about, the $109 to the -- is that an adjustment?

MR. PETTENGILL: That's evaluated at the USPCC. So the actual range is even greater because you've got low rate counties and high rate counties.

MR. MacBAIN: Do you have any sense of how that looks when you apply this to the floor counties versus Staten Island?

MR. PETTENGILL: I can't do that in a sense because I don't know what the rescaling factors are for the counties, and I think you'd probably want to take that into account. That's part of the problem with rescaling is nobody really has a sense of what those look like yet, how big are they.

MR. MacBAIN: When do we get those?

MR. PETTENGILL: I think you'll probably get them January 15th, although they might be making that information

available earlier.

MR. MacBAIN: They go from 35 to one to 3,500 to one?

MR. PETTENGILL: I think that's part of the problem here is there's so much uncertainty. People are a little bit put off, scared what might happen.

MR. MacBAIN: What would it be without the scaling factor?

MR. PETTENGILL: The floor would be $387 or something like that and the highest is up around $800. It would shift --

MR. MacBAIN: What's the USPCC, adjusted for the floor?

MR. PETTENGILL: It's about $460, maybe a little bit less, $458.

DR. WILENSKY: Julian, all of the strategies that HCFA has been talking about introducing like their disease management for congestive heart failure, which is basically spending money to keep people out of the hospital, and what we were hearing yesterday from Joanne Lynn about how to try to keep people in their terminal phase out of the hospital

means that any of those people are going to be anathema to the managed care plans. That's the last thing you want to do is keep people from being rehospitalized either in the terminally ill or if they have stage three or four congestive heart failure.

MR. PETTENGILL: That's one of the issues that the people I think from the plans primarily were raising at the meeting. All of this is calibrated off the fee-for-service baseline. And because of the concern about potential gaming they went back through and took out a lot of the discharges for the 75 DxGroups where the physicians said the admissions are often discretionary, and they also took out all of the one-day stays.

Now it's not to say they took those out and threw them away. They didn't. They just said essentially -- they put them into the base category. Which means the base DCG is combined with the age/sex categories. So in effect, all the patients in the base DCG, including the 75 DxGroups and the one-day stays, are allocated across the age/sex categories.

DR. NEWHOUSE: It seems like we've lurched from

one extreme to the other. The old system we had fully interactive system, age, sex, institutional status, Medicaid status was all -- everything was its own cell and the AAPCC calculated or the rate book calculated the cell mean at the national level. Now, if I take this right, we've completely eliminated all interactions, and one of the things we might do is just examine the sensitivity to that because there's got to be some interactions floating around in there that will be important. Maybe HCFA is going to do that on their own. At least calculate the first order interactions and see what's there.

MR. PETTENGILL: I think the first thing we want to do is talk to the people who have actually done this work and see whether they've looked at all that, because if they did I'm not sure it's worth repeating it.

DR. NEWHOUSE: Fine. No, there's no need to repeat it if they've done it.

MR. PETTENGILL: But that's an issue. Another issue is that this is based off 1995 and 1996 5 percent sample claims. Would you get the same numbers if you used 1996 and 1997, or 1994 and 1995?

DR. NEWHOUSE: Or if you used a bigger sample. I mean, 5 percent is a little thin for estimating even some of the main effects probably, let along interactions.

MR. PETTENGILL: Right.

DR. NEWHOUSE: Did they say anything about the second, third, fourth year and so forth, the work that we did showing that if you were hospitalized in year one you had higher expenses in years three and four? Or did they just say what they were going to do in year two?

MR. PETTENGILL: This is a one-year model and there is no lasting effect. Whatever bump you get from a discharge last year is you get it, and that's it. It's gone.

Now I did talk with one of the staff people about the possibility of using kind of a multi-year model to kind of cushion the effect somewhat. But I think that would be extremely difficult to do here because of the way the DCGs are defined. That is, you've cobbled together --

DR. NEWHOUSE: You can roll it out. Maybe you can't do it initially, but...

MR. PETTENGILL: No, the problem I'm thinking of

is that a DCG contains a lot of different DxGroups. Some of them will have a continuing effect at a certain level in the second year. Some of them won't. Some of them will have a bigger effect in the second year, and they're not homogeneous at all. They weren't formed --

DR. NEWHOUSE: In analyst heaven you might do a different grouping in year two, but even if you didn't do that it's very likely that you're going to have higher average spending --

MR. PETTENGILL: This isn't analyst heaven?

[Laughter.]

DR. NEWHOUSE: Maybe steps removed. Stuart says that MedPAC is, but not HCFA.

MR. PETTENGILL: I mentioned that possibility to one of the staff people over there and the reaction --

DR. NEWHOUSE: What, to come to work for MedPAC?

MR. PETTENGILL: No, I didn't mention that. I didn't have Murray's authorization to do that.

[Laughter.]

MR. PETTENGILL: And the reaction was that they thought it would be really extremely messy to do it. So

these problems in the short run are really -- they're not going to be resolved easily, that's for sure.

The last point here is that there really is likely to be a fairly substantial decline in aggregate payments to plans, not because of the rescaling but because the new risk scores will, to the extent that plans have enrolled people who are healthier, it's going to show, and the payments are going to come down. That's what, of course, a lot of people from the industry were concerned about yesterday.

So now we can talk about specific issues, some of which we've already talked about a little bit. One of them is this issue of, do you phase it in?

DR. WILENSKY: What was the issue?

MR. PETTENGILL: Whether you phase in the risk adjustment.

DR. NEWHOUSE: But couldn't the plans argue that they have the same sickness but they just didn't hospitalize?

MR. PETTENGILL: I was going to come to that because that's wrapped up in whether you add the selected ambulatory data or not. But yes, they are really concerned

about that plan because the system has been calibrated on fee-for-service and they say, our practice pattern is different. So partly you're going to penalize us because we hospitalize people less frequently. I'm not sure that has an answer, except that --

DR. WILENSKY: It doesn't have a short term answer.

MR. PETTENGILL: I was about to follow with HCFA's answer. HCFA's response to that is to say, we tried to be really conservative about this, so we're not redistributing all that much money with the health status part of this. Something like 18.6 percent of the population in any year is hospitalized; 80 percent has an encounter with the health care system of one kind or another. Right now the DCGs catch 12.7 percent --

MR. ZABINSKI: No, it's 12 percent after --

MR. PETTENGILL: They're planning further modifications that will reduce it to 12.

DR. WILENSKY: 12 percent of the 18 percent --

MR. PETTENGILL: 12 percent of the beneficiaries--

DR. WILENSKY: That 18 percent goes down to 12

percent?

MR. ZABINSKI: That's right.

DR. NEWHOUSE: So that means 6 percent go into the default category because they were discretionary?

MR. PETTENGILL: Right.

DR. CURRERI: Or one-day admissions.

MR. PETTENGILL: Or one-day stays, right. Although they said that moving most of the discretionary DxGroups into the base takes care of most of the one-day stays although there are some left.

Those 12 percent account for about -- sorry I lost it. They had a nice little chart that -- here they're talking about the 12.7 percent which they're going to reduce they say to 12, which accounts for -- it's 20 percent of the money, I believe, is what gets moved by the PIP DCGs. It's more than that, but you have to remember that the same people who were hospitalized would have had scores based on their age/sex categorization and the other demographic factors in any case. So they say essentially, look, we're moving 20 percent of the money here from one place to another with this system, so it's not that bad. We're not

going to affect the plans that much.

But on the question of whether you phase in the risk adjustment to cushion its impact, their reaction was, we don't really want to talk about phase-in until we've seen the encounter data and we see what the impact is because we may not need it. If it turns out that they do need it, then their preference is along the lines of establishing corridors, setting the maximum change up or down that a plan could experience, but the width of the corridor, of course, is unknown at this point.

Now the adjustment for encounter reporting lag refers to this problem that when you go to characterize enrollees, you do so on the basis of the encounter data that was submitted by the plan in which they were enrolled. But at the point at which -- at the beginning of the calendar year when you have to say what group the person belongs to you don't have all of the encounter data for the preceding year. It's not yet in. So they'll have data from the previous July to the June preceding the calendar year in question.

And the question is, do you pay on -- do you

establish the category the person belongs to, and therefore the payment rate, based on that six-month lagged data and then make a retroactive adjustment the following summer when you have the remaining six months in? Or do you just establish a rate based on the lagged data and not worry about it, not make a retroactive judgment?

Their position there was basically, we'd like to know what the industry thinks; which way would you rather have it? Because in the aggregate it probably doesn't matter to HCFA. So that's that issue.

Developing an outlier policy, you're predicting relatively low rates for some people who were not hospitalized during the prior year and a plan could get cases where they have to spend $150,000, $250,000, whatever, to care for somebody who has a serious illness. Would it be worthwhile thinking about how to deal with that, particularly for the smaller plans?

DR. CURRERI: Julian, are all new entrants at age 65 classified in the lowest group?

MR. PETTENGILL: No.

DR. CURRERI: Assuming that they don't have a

previous disability.

MR. PETTENGILL: They said that's one of the things they're still working on. I got the sense that what they're planning to do is develop a special set of base age/sex category estimates that relate to new enrollees and use those, because they won't know what the hospitalization experience is. That's what they seem to be saying they were going to do. But they hadn't worked it out yet so they weren't really going to talk very much about it.

MR. MacBAIN: A question on the lag again. The DCG data is used to predict fee-for-service costs in the year following the year of the admission?

MR. PETTENGILL: Yes.

MR. MacBAIN: But in practice it's going to be used to produce payment rates two years following the admission?

MR. PETTENGILL: No. At the beginning of the calendar year you're going to pay for you would know whether the person was hospitalized in the prior -- not the prior six months, but the 12 months before that. So beginning 18 months prior and ending six months prior.

MR. MacBAIN: So there's a slip of six months in there.

MR. PETTENGILL: That's right. And the question is whether --

MR. MacBAIN: What impact does that have?

MR. PETTENGILL: I don't know. On average it probably doesn't have any impact because you're going to have some that you say weren't hospitalized because in the 12-month period for which you have data they weren't. But in the following six months when you get it you'll see that they were. That should raise the rate.

But likewise, you're going to have the opposite case where they were hospitalized in the six months in the prior calendar year but not during the 12 months of the current calendar year. So you're going to have given too much money for them. I think it washes out.

DR. KEMPER: I had two questions. One is, to what extent is this system that gets implemented now will that be locked in and for how long? I guess if I were in a plan's position I wouldn't want it to change year after year after year. On the other hand, just in this brief discussion

we've identified a number of problems or potential problems with this system. Is this going to be it for a few years until the encounter --

MR. PETTENGILL: I think so. They're not going to collect the other data, outside of the inpatient setting, until at least after October 1st next year. And then they want three years of data before they would try to implement something new. That puts you out at 2003. In fact, it puts you out longer than that I think because we're setting rates this January for the year 2000. So you've got to take that lag into account, too.

DR. KEMPER: My second question is, how subject to revision is this plan? I mean in the next month. We had suggested some notion of taking a longer time period over which one measured diagnoses than a year.

MR. PETTENGILL: I think there's no hope for that.

DR. KEMPER: It's not technically --

MR. PETTENGILL: Certainly not for calendar year 2000 because what you would have to do between -- in order to do that it would have to be done before December of this year in order to get it in place, and there's no way.

DR. KEMPER: And the problem is the technical one of doing the analysis?

MR. PETTENGILL: Yes.

DR. KEMPER: They just couldn't go back several years and --

MR. PETTENGILL: No.

DR. NEWHOUSE: What hope is there for an outlier policy?

MR. PETTENGILL: I don't think there's any for calendar year 2000.

DR. NEWHOUSE: So the only hope, the only change would be a phase-in, in your view?

DR. KEMPER: No, there's selected ambulatory data.

MR. PETTENGILL: Right.

DR. KEMPER: That's out of the question also?

MR. PETTENGILL: I don't think there's much hope for that one either. Frankly, the idea was to go out and get survey data that you could use that would help you to set the rates. But you've got to do more than -- first of all, you've got to change the classification system so it reflects that data. So you're surveying to get the base

that you're going to use with the fee-for-service data to alter the classification and reset the weights. Not a small job.

Second, and this is the real rub. When you get to the point where you're going to pay the plan, you've got to be able to characterize the patient. What category do they belong in? Where do you get that? It means you have to have it for everybody. Where does it come from?

The plans have basically said that they can't handle, very quickly anyway, the outside encounter data, the ambulatory data.

MS. NEWPORT: HCFA has problems there too.

MR. PETTENGILL: Yes, it's not just the plans, it's also HCFA. And I suppose that Y2K figures in here a little bit, too.

MR. MacBAIN: To go back to the application of the new factors to the USPCC where the low rate drops from $282 to $109 and the high rate goes up from a little over $1,000 to over $3,500, how does that reconcile with HCFA's statement that you're only moving 20 percent of the money? Because with these extremes, it's a lot more.

MR. PETTENGILL: Because these numbers, these are the extremes, and what this doesn't reflect is the incidence that goes with the different payment rates. At the very high end there aren't very many people. Those DCGs -- they've got a list in one of their overheads where they identified what percentage of beneficiaries were in each of the DCGs. You can see that in the low and middle ones it's fairly substantial percentages. Like DCG-8, which runs around $8,000, $9,000, is 2.7 percent, and 10 is 3.2, 12 is 3.2. But when you get up to 20, you're down to .3 percent, and 23 is .6, 26 is .1, and 29 is .1. That's where the money is -- the big money.

DR. NEWHOUSE: I'm remembering when tracheostomy was first introduced into the DRGs with a weight of I think around 11 or so, there was a factor of 10 increase in tracheostomy admissions.

MR. PETTENGILL: No, not so.

DR. NEWHOUSE: Yes.

MR. PETTENGILL: What happened is that the tracheostomies that hadn't been recorded before because it didn't matter, were recorded.

DR. NEWHOUSE: Yes. We agree.

MR. PETTENGILL: It's not that people started being admitted --

DR. NEWHOUSE: But another way of saying that is that what appeared to be a rare thing became not so rare.

DR. WILENSKY: For payment purposes.

MR. PETTENGILL: Absolutely. But I think if you were to look at what's in this DCG-29 -- I mean, these are things that there's no question that if they were hospitalized for this and this was the principal diagnosis, it would have been recorded, because of the DRG system, if nothing else. These are high cost cases. HIV/AIDS, blood/lymphatic cancers, neoplasms, nervous system cancers. These are pretty highly paid.

MR. MacBAIN: But HIV/AIDS is a good example of where you could have subsequent admissions in subsequent years at relatively low cost, just to make sure that somebody stays in that high DCG, given the lack of persistence of the data.

MR. PETTENGILL: Right. Gaming is a real potential issue.

DR. WILENSKY: Janet and then Alice.

MS. NEWPORT: I'll try to keep this simple. Maybe a simple measure of what bad shape we're in is relative to the numbers of words that start with the prefix RE: recalibrate, rescale, refine. I just offer it up because I need a little amusement right now.

DR. NEWHOUSE: Retreat.

[Laughter.]

MS. NEWPORT: Anyway with that said, I would compliment you on the paper in our materials. It's about as cogent and crisp a description of what the state of play is right now, and I appreciated that very much, because it's difficult enough to describe if you're dealing with it all the time, much less try to explain it to other people.

Let me suggest a couple of things. Obviously there's a lot of issues that have come up now. There are serious infrastructure issues that I think we need to try to look at a little bit here that aren't mentioned specifically. I know HCFA is dealing with some of them, but we have to measure how well they complete some of these tasks.

For example, my company did a beta testing of 1,700 claims files and only 60 of them were able to attach to the common working file. And I've heard anecdotally from other companies that -- and we only have 400,000 more to go so we're --

MR. PETTENGILL: They said they have solved that problem and it's now working. That's part of the delay in the date.

MS. NEWPORT: I understand some of that. But I think there are other issues too that seem to have come to the fore. If they're getting solved, that's good. But we need to understand that for general policy purposes.

I'm really concerned about timing in terms of -- and accuracy, because we have to rely totally on a retroactive data set for estimates of what payments will be next year so we can file for 2000. I think we need to just acknowledge that somehow and keep our eye on that. I think it's a really critical component of this.

I just am very concerned about the smoothing issues. The response that was conveyed to me after yesterday's meeting was that our technical people in the

industry are still concerned about data mapping issues, the underpinnings of the methodology so that we can actually do our own calculations on what the impact will be.

There's still some core questions that I think have been raised here as well. The one-day stay issue seems to be of concern, and the being able to use an abbreviated data set in the near term so that you can at least get something attached to the common working file.

Again, these are process issues, but they're no less important than some of the more theoretical issues. I guess it would be helpful maybe if you could give your impression of the meeting in terms of, am I accurately reflecting what you might have heard yesterday?

MR. PETTENGILL: There was certainly a lot of discussion of those issues of getting the data in effectively, where it was, whether it had been transmitted by the plans to the intermediary they've chosen to be the receiver, and how much of it had gotten to HCFA and what the problems were, and whether they were being resolved. I think there's a lot of problems occurring there, but I think within a few weeks that will all be pretty much worked out,

at least in terms of getting the data in.

Now where do you go from there? These issues of sample size and the potential volatility of the numbers seem to me to be pretty worrisome.

DR. NEWHOUSE: I want to call on Alice, but let me ask a clarifying question. If they put in a floor to deal with the volatility, would that be budget neutral, or did they say?

MR. PETTENGILL: What's the floor apply to here that you're thinking about?

DR. NEWHOUSE: I'm assuming that you just bound the decrease. If some county was going to get a 30 percent decrease because in one year --

MR. PETTENGILL: You're talking about the corridor issue --

DR. NEWHOUSE: So we said, we're not going to lower anybody more than 7 percent or whatever. Is that going to be budget -- I assume that's what you had in mind with the corridor, or what they had in mind.

MR. PETTENGILL: I think that's what they have in mind.

DR. NEWHOUSE: Did they say whether that would be budget neutral?

MR. PETTENGILL: No. But I would imagine that if you were going to do this, you would want to make it budget neutral. I don't know. It's hard to discuss something like that with someone who isn't yet prepared to discuss it. They're not going to tell you everything about it. I mean, they may not have thought it all the through.

DR. NEWHOUSE: You mean not prepared to discuss it because OMB hasn't cleared a final rule or what?

MR. PETTENGILL: No, it's more a matter of, we're working on that and we're thinking along the lines of using something like this but we're not going to -- I'm not going to describe it fully to you because I don't have it all worked out. Or, this is something that has to be approved by six other people, so at this stage it's just an idea. And moreover, the actuaries will certainly have a hand in what this looks like in the end.

DR. NEWHOUSE: Sounds like a good segue to Alice.

MS. ROSENBLATT: You can always blame the actuaries.

I also want to agree with Janet and say that the presentation of very difficult material was done extremely well and I really appreciate the effort that both of you put forth on that. I think it really did try to clarify some of the very complicated issues.

I'm still not sure that I understand the payment question. Joe, I may need your help here. If we have a model that took diagnosis from '95 and calibrate it based on payment for those diagnoses a year later. That's the calibration model that you described. Then it would seem to me the way to create a working model that does the same thing is to say, okay, if we're applying this to the year starting 1/1/2000, and then if we're going to do an exact -- let's do it the way the calibration was done, we would take diagnoses during a 12-month period, 1/1/99 to 12/31/99, track that, and then the member connected with that, wherever that member is, that determines the payment.

But you're saying that's not what's going to happen. We're going to be using some prior -- there's more of a time gap than the calibration model.

DR. NEWHOUSE: Another six months.

MR. PETTENGILL: You have to distinguish between the weights and the assignment of the weights.

MS. ROSENBLATT: That's what I'm trying to do.

MR. PETTENGILL: The weights for calendar year 2000 will be the weights based on the 1995 and 1996 data.

MS. ROSENBLATT: I understand that.

MR. PETTENGILL: The question is, which category does a person belong in?

MS. ROSENBLATT: Correct.

MR. PETTENGILL: And that is based on -- at the beginning of calendar year 2000 that cannot be based on the full calendar year of encounter data because you don't have it.

MS. ROSENBLATT: Right.

MR. PETTENGILL: So it's going to be based on the prior -- a 12-month period ending six months earlier. That is, ending June 30th, 1999. That will be the basis for establishing initial rates that either could be interim rates which are retroactively adjusted six months later when you have the full calendar year's data, or they could be

just the plain rates.

MS. ROSENBLATT: And they have not made that decision yet?

MR. PETTENGILL: That's right. And they were interested in what the industry thought, which way the industry would prefer it, because I think from HCFA's perspective it doesn't matter.

MS. ROSENBLATT: I don't know what Janet would say, but I would vote to finalize it. I would not vote going out -- to me, there's enough uncertainty in this whole system right now that I'd say --

MR. PETTENGILL: You'd rather not have the correction.

MS. ROSENBLATT: I'd rather not have a correction the first year out, yes.

MR. PETTENGILL: Send them an e-mail. Really, that's what they're asking for. Not just the comments on the notice, but they were literally asking people to submit questions, to send them an e-mail and tell them what they think.

MS. ROSENBLATT: But my other question is, does

that -- and I haven't played around with these models enough to have any feel for them, but Joe, do you think there's sort of a big disconnect them between the calibration and the way it's being implemented because of that time lag?

DR. NEWHOUSE: Some. But it doesn't sound to me like that's anywhere near the top of the list of problems here.

MS. ROSENBLATT: Okay, let me keep going then.

DR. ROSS: Can I ask Alice a question, because your second question -- on the basis of your first, I thought I heard you say you're not sufficiently worried about that disconnect; that you'd rather just have no correction because of the chance of error. But then your second question was how big was the disconnect. So did I understand your first question?

MS. ROSENBLATT: My intuitive sense, without having actually tried it out, what my intuitive sense is, I agree with Joe that it's not a big deal.

DR. ROSS: So we're saying year two looks a lot like year three.

MS. ROSENBLATT: But I'm concerned about two

things. One is, I think there's so much uncertainty that having an interim payment and a settlement introduces another degree of uncertainty to plans that are struggling financially. So I would rather not have the financial uncertainty of the interim payment, particularly if it can go in either direction. I think whenever there's a possibility of pulling money back you get into real trouble.

Then my second point on that would be, there would need to be accounting standards set up and all kinds of things to accrue for that uncertainty out there. And if you make the assumption that it's all going to wash out, then the plans that need to cough up money at the end are going to be in serious financial trouble. So for all of those reasons I would say, don't do that.

MS. NEWPORT: And I would concur. My gut reaction at that was, that's small comfort if you have doctors' payments were either too low, which is still bad, and then would go lower, or too high and then you have to take it back from them. It's very destabilizing. Your contracts are more than -- they're not renegotiated annually. We go longer term contracts, and all sorts of things are driven by

that. I think that is an additional problem in terms of uncertainty.

MS. ROSENBLATT: Great point. Playing what I said out to the health plan and playing that out down the food chain to the provider makes it even worse.

Was there any indication -- somewhere in the paper that you prepared for the meeting, not what you presented here, but there was a comment about some actuary from a health plan had estimated a 40 percent decrease in payment.

MR. PETTENGILL: That was in Medicine and Health. It was a quote from an unnamed manager of a health plan in Ohio.

MS. NEWPORT: I know who that is.

MR. PETTENGILL: You think you know who that was?

MS. NEWPORT: I think I do.

MR. PETTENGILL: I think that point was, we only put that in there to indicate that there are a lot of people out there who are worried about the potential decline they might be facing.

MS. NEWPORT: But in fairness, I don't think anyone has, until maybe yesterday or the Federal Register

notice, had the ability to get close to what the impact would be, using what HCFA would use. And there's still a gap.

DR. NEWHOUSE: We have to say what we're going to say in a comment letter, and I at least would come to phase-in.

MS. ROSENBLATT: That was my next point. My question was going to be, did they give any indication of how big the gap would need to be before they would --

MR. PETTENGILL: No.

MS. ROSENBLATT: Then my recommendation -- I have two recommendations which I was building up to. One is, I think we should recommend a phase-in, which we already recommended, and I think we should just reiterate it.

But two -- and Stuart and I were talking about this over lunch -- I think I would like to see the MedPAC staff set up some monitoring of payments once we get to 1/1/2000. I think we need to set up something that will show the variability of payment. And also, maybe even now start tracking enrollment issues like we were talking about, because we're saying we kind of know from newspaper stories

which plans are withdrawing from areas, but we don't know where plans are stopping marketing and things like that. But if we track new enrollees we may be able to get those red flags that we keep talking about, early warnings.

Finally, just an aside comment about, now I hope everybody understands why I've been saying we need the implementation details, we need the implementation details, because I think this is illustrated in a lot of the stuff I was worried about.

DR. KEMPER: I just think in combination with that we ought to reiterate the, move as quickly as possible to encounter data and to a longer period over which diagnoses are measured, because the phase-in, that's just the short term solution. That doesn't do much except slow things down and give them time --

DR. NEWHOUSE: It mitigates the moral hazard problem on admissions.

DR. KEMPER: It does that.

DR. WILENSKY: But it also gives some time -- I think it's important what Peter is saying, is that if we say both phase-in so you mitigate the unintended consequences,

and at the same time use that phase-in period to begin to do the things that aren't being done like the ambulatory data selected -- or however, and to begin to do multiple year effects, that that would allow you, presumably, if you think about that occurring over a three or a four-year period, by the end of the first three or four-year -- by the time you get it fully phased-in you ought to be in a position to make up the worst of the omissions.

DR. NEWHOUSE: Also I think we have to draw attention to the volatility issue, although how real that will be will obviously depend on where these floors and ceilings are set, which is open.

MR. PETTENGILL: Right.

DR. WILENSKY: The potential for volatility in some of the small markets is enormous. I think that that is also something in our comments where we should indicate that if HCFA appreciates it -- and they may well -- I think that Congress does not.

DR. NEWHOUSE: It will when the payments go too high.

DR. WILENSKY: Absolutely. And I don't know

whether -- it's not, obviously, as a note to HCFA, this issue about to what extent can MedPAC monitor changes, withdrawals, or slowdowns by county, by market. I don't know whether I agree -- I think this is an issue that would be better to start monitoring so we can get some early warning as opposed to a year after the fact. I don't know whether we can do that, but I think it's something that to the extent that we are in a position to start doing this, to be able to put some empirical evidence behind what you read in the newspaper will be very useful. And this is only one of several reasons why it might occur.

MR. PETTENGILL: Right. In the past we've used the group health master file to track enrollment by plan.

DR. WILENSKY: But because it will have enormous implications for premium payments for seniors who find themselves forced into Medigap, I think it will become a very sensitive issue, if in fact it occurs. So it's not just a question of whether the growth is or isn't what CBO projected, or what happens to the financial health of some of these health care plans, is what it means for seniors who otherwise would have had this as an option.

DR. KEMPER: Calls to Congress will be the early warning indicator.

DR. WILENSKY: Absolutely, yes. In a way, we've seen at least early indications of concern about home care, but this is really not a consumer-driven issue at the moment. It's an institution-driven issue. But if you get this kind of change that we're reading about potentially on the horizon, it could be much more the beneficiaries than the plans.

So anyway, to the extent that we can start monitoring it, it has the potential for having a lot of repercussion.

Any further comments?

We will, I assume, get something circulated so that we can -- will we be able to circulate something before October 6th? It's not very long?

DR. ROSS: It's 18 days? We can certainly get something out that reiterates where we are. Whether we'd want anything that's dramatically new --

DR. WILENSKY: No, I assume they can't -- just to have people have a chance to make comments so they can --

and we will understand the very short turn-around.

Thank you, that was a very lucid presentation of a complex area.

Let's open it to public comment, if anyone wishes to say something.

MS. MILLER: I'm Marianne Miller from the Health Insurance Association. I'm not prepared to enter into any technical discussion at this point but I would like to underscore the concerns that you've heard from the two members from plans, and let you know that we have commented to HCFA with concerns on risk adjustment and have given you -- Murray has a copy of our comments. It occurs to me that if there's anything that we can do with our members to help you monitor the early implementation, we can explore that. We might be able to do something.

Thank you.

DR. WILENSKY: Thank you. Anyone else want to raise an issue?

Thank you. Our next meeting is toward the end of October. It will be here. We will make sure that the schedule is available both electronically and in paper form,

and accurately.

[Whereupon, at 3:07 p.m., the meeting was concluded.]